Perceptions of attachment in adolescent girls with eating disorders, clinical depression or both

Thesis

UNRESTRICTED

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PERCEPTIONS OF ATTACHMENT IN ADOLESCENT GIRLS WITH EATING DISORDERS, CLINICAL DEPRESSION OR BOTH

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DECLARATION OF CONFIDENTIALITY

In order to preserve the anonymity of participants, all names cited in this paper are fictitious and some minor identifying details have been omitted or altered.

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ABSTRACT

Despite the wealth of research based on Attachment Theory and growing interest in Adolescence, there remains a scarcity of research assessing adolescent attachment. This study examined insecure attachment perceptions in two groups of clinical adolescents: girls with eating disorders, some of whom also had clinical depression and girls with clinical depression but without eating disorders. These two clinical groups were matched with a third group of non-clinical controls. There were ten adolescents in each group. Participating adolescents completed self-report questionnaires pertaining to symptomatology, attachment and family functioning: The Parental Bonding Instrument (PBI); the Adult Reciprocal Attachment Questionnaire (ARAQ); the Separation-Individuation Test of Adolescence (SITA); the Family Adaptability and Cohesion Scales II (FACES II); the Youth Self Report (YSR); The Beck Depression Inventory II (BDI II) and the Stirling Eating Disorder Scales (SEDS). Parents of adolescents, of whom thirty participated in total, completed the (Young) Adult Self Report (YASR), the PBI, FACES II, BDI II and ARAQ. Five adolescents per group additionally participated in an attachment interview.

Significant levels of pathological maternal bonding and impoverished family functioning were reported by depressed adolescents only. Higher levels of maltreatment and neglect were also reported by this group. Significantly higher levels of enmeshment and overprotection were reported by eating disordered adolescents only. Clinical adolescents in both groups demonstrated impaired reflective functioning (mentalising), with eating disordered girls showing the worst levels. There were within-group differences in the eating disordered group only, between girls with and without comorbid depression, the former sub-group reporting significantly greater psychopathology. These results support correlations found between impoverished maternal bonding, pathological family functioning, insecure attachment and adolescent depressive psychopathology and between family enmeshment and eating disordered pathology within the research literature. A tentative theoretical framework is offered connecting 'disorganised' attachment with adolescent comorbidity and symptom severity. Methodological and ethical issues are addressed and implications for future research and clinical practice outlined.

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CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

Attachment Style and its origins in Adolescents with Eating Disorders and/or Clinical Depression

Adolescence must be one of the most challenging and interesting periods to study. There is a vast body of literature and research pertaining to this crucial development milestone. Attachment Theory too has ignited a wealth of interest since its inception by Bowlby in the 1940s. This review cannot provide a comprehensive overview of all the different aspects of this research, but will focus on particular areas. A brief general introduction to adolescent development and Attachment Theory will then focus down on theoretical and research literature relating to attachment insecurity within eating disordered and depressed individuals, particularly adolescents. Finally, hypothesised precursors for this insecurity will be discussed: childhood maltreatment; intergenerational transmission of insecure attachment; separation/loss experiences; lack of parental emotional containment* and cognitive dissociation / impoverished reflective functioning*.

1.1 Adolescent development: from 'storm and stress' to psychopathology

The phase of 'second individuation' (Blos, 1967), marked by the onset of puberty, heralds a time of intense physical, social, cognitive and emotional change (Tanner, 1989). Developing self-consciousness and social comprehension enables young people to reflect increasingly upon themselves, their world and their relationships (Piaget 1952, 1955; Keating 1990; Brooks-Gunn and Reiter, 1990). Since Blos (1962, 1967), separation-individuation has been considered by many to be the key developmental task of adolescence (Lapsey, Rice and Shadid, 1989). Blos (1962) particularly influenced psychoanalyst Erikson (1902-94) whose theory of adolescent 'identity confusion/diffusion' (Erikson, 1968) became renowned. It has, however, been disputed that all adolescents undergo 'storm and stress' (Hall, 1904; Coleman and Hendry, 1990). 'Normal' adolescence has since been understood as a period not of crisis but of consolidation (Lyddon, Bradford and Nelson, 1993), with the quality of early

* = please see Appendix 24 (Glossary) for detailed definition of terms marked with *

relationships laying groundwork for the success (or failure) of adolescent separation and alternative relationship formation (Sroufe, Carlson, Levy and Egeland, 1999). There is, nonetheless, a changing pattern of escalating mental health problems reported during adolescence (Rutter and Rutter, 1992). In particular evidence from epidemiological research and clinical studies indicates a marked rise in depression, anxiety, conduct disorders, self-harm and eating pathologies (Hill, 1993).

1.2 Early theories of adolescent psychopathology

Early psychoanalysts portrayed clinical adolescents as failing to achieve maturation, due to profound intrapsychic conflict in infancy and early childhood, which had never been overcome. The re-surfacing struggles for autonomy and control, together with a resurgent sexuality following the latency years was thought to cause the adolescent to "regress" in an attempt to resolve past conflicts (Masterson, 1977; Laufer 1997). Bowlby was among the first from within psychoanalysis to convincingly challenge this exclusively 'internal world' view and to acknowledge the crucial role of child rearing in later development and mental health (Marrone, 1998).

1.3 Bowlby and Attachment Theory

Attachment theory was developed by Bowlby to explain the parent-child bond. This he did in ethological*, biological and social terms, partly to account for disturbances observed in infants made to endure prolonged separations from their parents (Bowlby 1944). Bowlby's early theories of infant attachment focused on the centrality of the primary caregiver ('Monotropism'*) to a "secure" attachment relationship and the significance of adaptive, survivalist, proximity-related behaviours by the infant. He identified four main types of insecure attachment with proposed origins in inappropriate caregiving behaviour (Bowlby 1969, 1973, 1977, 1988): Within **Anxious Attachment / Compulsive Care-Seeking**, caregiving creates in the child a constant fear of losing the attachment figure. This occurs via unresponsive or discontinuous parenting, threatened interruptions of care or parentification of the child. **Compulsive Self-Reliance** occurs where the child's attachment behaviours are consistently rejected, so that he

learns for self-protection to cut off emotionally in order to maintain proximity to a rejecting caregiver. **Compulsive Care-Giving** relates to compulsive self-reliance. The caregiver is unable to adequately care for the child and requires / demands care-giving themselves (Bowlby, 1977). The result is a 'parental' child who suppresses attachment behaviours and activates care-giving behaviours, in order to maintain proximity. **Emotional Detachment** occurs where there is prolonged incidence of maternal deprivation, usually in tandem with rejection. The child, therefore, is unable to form emotional attachments at all.

Bowlby later extended his view of attachment (Bowlby, 1985, 1989), to incorporate a cognitive 'Internal Working Model' (IWM) * or mind state in respect to attachment (Main, Kaplan and Cassidy, 1985), whereby internal representations made by the child of the caregiver acted as a cognitive template for later relationships (Bowlby, 1969). This provided a convincing explanation of how infants' representations of relationship experiences became incorporated into their personalities and cognitive structures. Whilst these internal manifestations were acknowledged to be modifiable by later experience, they were also thought to be resistant to change (Bowlby 1973; 1988).

1.3.1 'Disorganisation': a fourth attachment category

Bowlby's ideas were refined and developed by his contemporaries and successors, notably by his student Mary Ainsworth (Ainsworth and Wittig, 1969; Ainsworth 1985). It was Ainsworth who first developed the notion of a 'Secure Base'* (Ainsworth, 1985, 1989), demonstrated by means of the "Strange Situation" * laboratory playroom experiments which assessed attachment security in one-year-old children. Ainsworth used results from her studies to develop her own theory of different patterns of attachment, which she termed **Secure (Type B), Anxious/Avoidant (Type A)** and **Anxious/Ambivalent (Type C)**. These paralleled Bowlby's 'Compulsive Self-Reliant / Compulsive Care-Giving' and 'Anxious' categories respectively.

Ainsworth and others later added a fourth category, the **Disorganised / Disoriented (Type D)** (Main and Solomon, 1986; Ainsworth and Eichberg, 1991), where children showed a diverse

range of contradictory responses upon separation. This category seems related to Bowlby's 'Emotionally detached' classification and was often accompanied by a history of child maltreatment (Main and Solomon, 1986; 1990). 'Disorganisation' is classified according to the 'Strange Situation' as a sequential and simultaneous display of contradictory behaviour:misdirected movements, freezing/stilling, apprehension of the parent and disorientated behaviours (Schuengel, Bakermans-Kranenburg and van IJzendoorn, 1999). 'Disorganised' attachment in childhood has been shown to be highly correlated with dissociation in adolescence (Carlson, Cicchetti, Barnett and Braunwold, 1989) and adult psychopathology (van IJzendoorn, 2000).

1.3.2 Attachment beyond infancy

Early patterns of attachment have been shown to hold into later childhood and adolescence (Matas, Arend and Sroufe, 1978). Secure infants become secure children (and, by implication, secure adolescents and adults), demonstrating greater positive affect and social competence than insecure individuals (Kobak and Sceery, 1988; Bretherton and Waters, 1985). Avoidant infants become children and adolescents who cut off from anger or distress-related affective displays (Kobak, 1986; Lutkenhaus, Grossman and Grossman, 1985), while ambivalent children exhibit heightened expressions of distress (Kobak, 1986).

Within adolescence more specifically, Bowlby perceived a correlation between experience of insecure attachment in infancy and adolescent disturbance (Bowlby, 1944). Existing research on attachment in adolescents has revealed, perhaps unsurprisingly, that adolescents who report more secure attachments to parents in childhood tend to also be more securely attached in adolescence and to report more emotional security with friends (Kobak and Sceery, 1988).

Whilst there have been criticisms of Attachment Theory, notably its tendency to see insecurity as fixed and enduring (Hazan and Shaver, 1994; Rutter. 1995), its focus on infancy (Larose and Boivin, 1998) and its neglect of consideration of other factors in the aetiology of psychopathology (Sroufe et al., 1999), the theory nonetheless provides a helpful conceptual framework for understanding adolescent disturbance, particularly in light of evidence of the stability of attachment patterns across time (Goosens, van IJzendoorn and Tavecchio, 1986;

Main et al., 1985).

1.4 Measuring attachment in adolescence

One of Bowlby's unique contributions to psychological research was in making psychoanalytic conceptualisations quantifiable (Hobson, Patrick and Valentine, 1998). As attachment research has focused primarily upon mother-infant interactions (Ainsworth, Blehar, Waters and Wall, 1978) or adult attachment (Hazan and Shaver, 1987), there is, however, a notable lack of adequate attachment measures developed specifically for adolescents (Toth and Cicchetti, 1996; Scott Brown, 1999). Those measures that do exist, for example, the Inventory of Parent and Peer Attachments (IPPA – Armsden and Greenberg, 1987) or the Adolescent Separation Anxiety Interview (ASAI – Richard, Fonagy, Smith, Wright and Binney, 1998) tend to lack methodological robustness (IPPA) or focus on one aspect of attachment behaviour only (e.g. separation) (ASAI).

Existing measures for assessing attachment fall into three broad categories:

a) Self-report measures of parental behaviour during childhood (e.g. The Parental Bonding Instrument – Parker, Tupling and Brown, 1979).

b) Self report measures of general attachment style (e.g. Hazan and Shaver, 1987; West and Sheldon, 1988).

c) Interviews assessing mind state with regard to childhood experience (e.g. the Adult Attachment Interview, George, Kaplan and Main, 1985).

Different attachment measures conceptualise attachment differently (Feeney and Noller, 1996). Because of this, however, administering a range of different measures may be essential to ensure an accurate picture of attachment style. This procedure has, despite its problems, been followed within many of the major research studies on attachment in depressed and eating disordered patients conducted to date (O'Kearney, 1996: Sharpe, Killen and Bryson, 1998).

The Adult Attachment Interview (AAI*) is perhaps the best known and most empirically

supported measure of attachment (van IJzendoorn and Bakermans-Kranenburg, 1996). The AAI protocol was designed to probe alternately for descriptions of relationships, specific supportive memories, contradictory memories, assessments of relationships in childhood and current assessments of the same experiences and relationships (George et al., 1985).
A coding system exists for the AAI, which records "autobiographical competence" (Holmes, 1992) according to four main attachment classifications: Dismissing/Detached (DS or D), Preoccupied/Entangled (E), Unresolved/Disorganised (U) and Autonomous/Secure (F) (Main and Goldwyn, 1985). These latter have been shown to bear a systematic association to 'Strange Situation' classifications of infant patterns of attachment (Fonagy, Steele, Moran, Steele and Higgitt, 1991).

A different method of categorising the AAI has been undertaken by Fonagy and colleagues (Fonagy et al., 1991; Fonagy, Steele, Steele and Target, 1997), who developed the notion of "Reflective Functioning" (RF*), a similar concept to 'mentalising' (Kobak and Cole, 1994) or 'Theory of Mind' (Happe, 1994): the individual's ability to infer mental states in themselves and others. There is good evidence that attachment security is related to reflective capacity and coherence of narrative in respect to attachment (Kobak and Cole, 1994). The RF scale assesses an individual's ability to invoke mental state constructs: feelings, beliefs, intentions, conflicts and other psychological states in their account of current and past attachment experience.

Although designed for use with adults, the AAI has been shown to be applicable to adolescents' level of mentalising ability and cognitive functioning (Kobak and Cole, 1994) and has been used in previous research studies with adolescents (Kobak, Cole, Ferenz-Gillies, Fleming and Gamble, 1993).

1.5 Insecure attachment in eating disordered and depressed adolescents: A theoretical paradigm

Theoretical conceptualisations of attachment in eating disordered and depressed individuals again have roots in psychoanalytic writings. Bruch argued (1974, 1978), that adolescents with eating disorders fail to individuate due to maternal invasiveness and over-control. Later

analytically-informed writers (e.g. Chernin, 1985; Williams 1997) see the crucial crisis of the eating disordered adolescent girl as one of feared 'surpassing' of the mother. Chernin (1985) argues that this explains why eating disorders are so frequently found in families where there is an emphasis on achievement, intelligence and education. Williams (1997) talks of the 'no-entry' system of defences constructed by eating disordered adolescents against parental projections (and, one could add, actual intrusions). It has been suggested that fathers of eating disordered adolescent girls are often perceived as emotionally distant, rigid and superficial (Bruch, 1974) and that daughters as a result feel abandoned and rejected by them and even more unable to achieve healthy separation from the mother (Maine, 1993).

Using an attachment paradigm, girls with eating pathology could be seen as 'avoidant'. Anorexics particularly describe themselves as controlling, detached and unable to form or sustain meaningful relationships (Shelley, 1997). Adolescents developing eating pathology may do so as a way of warding off a depressive breakdown to which they would otherwise be prone (Williams, 1997). This would indicate a potential shift taking place from ambivalent attachment in infancy to avoidance and self-reliance in adolescence to avoid depressive affect (Bartholomew and Horowitz, 1991).

Similar theories have been generated in relation to depressed individuals (Crook, Raskin and Elliot, 1981). Beck's (1967) cognitive model of depression explicitly attributed the development of negative schemata and cognitions to a critical disapproving parent. Blatt, Wein, Chevron and Quinlan's (1979) psychoanalytic formulation followed Freud and others (e.g. Abraham and Whitlock, 1969) in suggesting that vulnerability to depression is linked to impoverished early parenting experiences, especially rejection and overprotection by both parents (Parker, 1993).

Bowlby proposed (e.g. 1969; 1977) that disturbed patterns of parental bonding have a profound negative impact on the psychosocial development of children, placing them at risk for depression. He believed that depressed adults had frequently experienced being told that they were unlovable or incompetent as children, or had experienced actual loss of a parent, with accompanying feelings of helplessness. This exposition fits both with loss theories of

depression (Brown, Harris and Bifulco, 1986) and those concerned with the quality of early parenting experiences (Rutter, 1981).

What psychoanalytic and attachment theorists neglected to discuss adequately was the contribution of whole-family dynamics to the prevalence of eating and depressive pathology among adolescents. This has been addressed by systems theorists (e.g. Minuchin, Rosman and Baker, 1978; Vandereycken, 1994). Palazzoli (1974) attributed the onset of anorexia in adolescence to suppression of family conflict, parental lack of leadership, marital dysfunction and inconsistent parenting style (Vandereycken and Meermann, 1994). Such difficulties frequently reflect problems within the marital relationship (Vandereycken, 1994). There is also evidence that parents of clinical children and adolescents show, significantly more than 'normal' families: rigidity; unwillingness to discuss disagreements; conflict; poor organisation and high levels of "expressed emotion" (Kog and Vandereycken, 1989; Richter, 1994).

1.5.1 'Control Theory'

Within the attachment literature, one of the most recent theoretical models for understanding attachment organisation within depressed and eating disordered adolescents has been devised by Kobak and colleagues (e.g. Kobak et al., 1993). 'Control Theory' follows Bowlby's conceptualisation of attachment as a homeostatic system. 'Preoccupied' attachment is produced where the system "hyperactivates" in response to intermittent or unpredictable caregiving, leading to an upsurge in attachment preoccupations and behaviours which enables the maintenance of proximity to an unreliable caregiver (Sable, 1997). 'Dismissing' attachment style occurs when the system, conversely, "deactivates", diverting attention away from attachment preoccupations, enabling the child or adolescent to survive the experience of rejecting, abusive or neglectful caregiving. It is argued that the adolescent's ability to perspective-take and self-reflect is directly related to their attachment strategies of hyperactivation or deactivation and that different discourses around attachment will therefore be elicited from hyperactivating and deactivating individuals (Kobak and Cole, 1994).

Cole-Dekte and Kobak (1996) (also Cole and Kobak, 1991; Kobak and Cole, 1994) related this model directly to adolescents with eating disordered and depressive pathology. They found

that adolescent girls with preoccupied attachments (hyperactivating) reported higher levels of depressive symptoms, whereas those with dismissing styles (deactivating) reported more eating disordered symptoms, when depression was controlled for. This offers empirical support to the notion that adolescents with eating disorders and depression exhibit specific and distinct attachment presentations, a finding upon which the present study is based.

One would predict from this that interpretation of self-reports by young people with eating disorders and depression would be problematic in different ways (Vandereycken and Vanderlinden, 1983). Those with eating disorders would be expected to deny problems, present an idealised image of relationships with parents and attempt to 'please' the researcher with socially desirable answers (Field, Morrow & Healy, 1991). Those with clinical depression would, however, be expected to dwell on distress and perhaps exaggerate it (Cole-Dekte and Kobak, 1996).

1.6 Insecure attachment within eating disordered and depressive adolescents: The empirical evidence

There is a considerable research literature correlating insecure attachment with eating disordered and depressive symptomatology (Sordelli, Fossati, Devoti, La Viola and Maffei, 1996; Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target and Gerber, 1996; O'Kearney, 1996; Ward, Ramsay and Treasure, 2000). Particular correlations have been found between both eating disorders and clinical depression and a lack of emotionally supportive parental relationships (Kenny, 1990; Kenny and Hart, 1992) and between anorexia particularly and dismissive / avoidant attachment style (Candelori and Ciocca, 1998).

Lavik, Clausen and Pedersen found (1991) that eating pathology was significantly correlated with maternal overprotection. Wertheim, Paxton, Maude, Szmukler, Gibbons and Hiller (1992) found similar trends, especially in binge eaters. Rhodes and Kroger (1992) also supported the maternal pattern of 'affectionless control' (Parker, 1983a), whilst substantiating Chernin's (1985) hypothesis in their discovery of high levels of separation anxiety within their eating disordered population. Studies of the quality of paternal bonding using the Parental Bonding Instrument (Parker et al., 1979) have revealed that 'affectionless control' was highly

prevalent among both mother-daughter and father-daughter relationships within this population (Calam, Waller, Slade and Newton, 1990).

With a depressed adolescent population, empirical studies have also consistently shown that psychopathology relates to failure to separate or individuate from parents, exhibited by pre-occupying behaviours such as 'separation anxiety' and 'engulfment anxiety' (Quintana and Kerr, 1993). Parker (1979a) and Cubis, Lewin and Dawes (1989) found that low maternal and paternal care scores on the Parental Bonding Instrument were correlated with adolescent depression and Parker (1982) demonstrated that a parenting style of 'affectionless control' could lead to depression in adulthood. Much research evidence associates adolescent depressive disorder and self-harm with poor mother-child relationships (Puig-Antich, Lukens, Davies, Goetz, Brennan-Quattrock and Todak, 1985 a, b) and, as with the eating disorder population, incidence of parental emotional unavailability and over-control (Richter, 1994).

Despite the wealth of research evidence of attachment disruption in eating disorders and depression, however, empirical uncertainty remains due to theoretical , measurement and methodological limitations (O'Kearney, Gertler, Conti and Duff, 1995).

1.7 Possible precursors of insecure attachment in clinical adolescents

1.7.1 Childhood maltreatment, parental 'frightening behaviour' and unresolved loss

Bowlby had argued (e.g. 1988) that psychopathology was a consequence of deprivation, ill-treatment, trauma or loss (Marrone, 1998; Bowlby, 1969). Because parent-child attachment relationships pre-date other relationships and are, therefore, thought to be particularly salient, the representational model formed as a result of maltreatment within these relationships would serve as a maladaptive template for later relationships (Cicchetti, 1991), inciting insecure and abusive attachments to recur throughout the child's life (Howes and Segal, 1993). This could be especially noticeable during adolescence, which is anyway a time of re-evaluation of attachment relationships (Coleman, 1980).

A large and expanding number of studies have substantiated theoretical correlations between early abuse, rejection and neglect, attachment disruption and psychopathology (Candelori and

Ciocca, 1998; Schuengel et al., 1999). Beginning in infancy, a far greater percentage of insecure attachment relationships with primary caregivers have been documented in maltreated youngsters (Lyons-Ruth, Connell, Zohl & Stahl, 1987; Main and Solomon, 1990). It is estimated that between sixteen and thirty percent of eating disordered patients have been sexually abused and that between ten and thirty percent have suffered direct or indirect violence within the childhood home (Schmidt, Tiller and Treasure, 1993). The figures are similar for depressed patients (Mollon, 1996). The most current review of research literature pertaining to attachment in an eating disordered population (Ward et al., 2000) highlights the need for further exploration of the theme of childhood abuse in this clinical population (p. 47).

Recent research at Leiden University (van IJzendoorn 1995; Schuengel et al., 1999) has extended the connection between maltreatment and insecure attachment to encompass parental 'frightening behaviour', by which unresolved loss or trauma in the parent creates unpredictable and emotionally uncontained parental behaviours, leading to insecure attachment in these children. The theory is based on the model of Main and Hesse (1990) and has been convincingly demonstrated through a number of robust, empirical studies (van IJzendoorn, 2000). Such findings provide a possible explanation for attachment disruption in adolescents where intentional childhood maltreatment has not occurred. The majority of studies examining 'frightening behaviour' have, however been undertaken with young infants only, which makes generalisation to an older age group unreliable. That different types of 'frightening parental behaviour' could impact significantly at different developmental stages does, however, seem plausible.

Crittenden (e.g. 1997a, 1997b) proposed a 'Dynamic Maturational' model to explain the impact of insecure attachment, occurring as a result of such early trauma upon the internal working models developed into adolescence and adulthood. Incorporating Tulving's (1985) theory of memory systems, she demonstrated how children exposed to parental abuse, neglect or 'frightening behaviour' learn to distort external information as a protective mechanism in the face of dangerous or unpredictable conditions. Such cognitive distortions then become generalised inappropriately to conditions where threat is not imminent. Integration of

information from different memory systems is prevented and cognitive 'splitting' occurs (Reimer, Overton and Steidl, 1996; Dozier, 1990).

Thus insecurely attached adolescents with past maltreatment experience could become hypervigilant to negative/rejecting/abusive responses from others and seek out confirmatory evidence for these (Batgos and Leadbeater, 1994). Such a model is supported by research, which has demonstrated that cognitive dissociation in adolescence appears to be one of the major sequelae of early childhood maltreatment and resultant attachment disturbance (Carlson et al., 1989). Fonagy and colleagues (e.g. Fonagy et al., 1996) found a clear connection between eating disordered patients and this type of impoverished reflective self-function.

'Maternal Deprivation*' was at the heart of Bowlby's initial conceptualisation of Attachment Theory (1944) and he believed that early loss was a crucial precursor to psychopathology. Empirical studies have substantiated this finding, particularly in relation to depression in adulthood (Brown and Harris, 1978; 1993). It has been demonstrated, however, that loss experience tends to precipitate later psychopathology only when there is already an existing vulnerability, via insecure attachment to the lost attachment figure (Parkes, 1991). The inadequacy of replacement care bereaved children may receive may be another vulnerability factor (Marrone, 1998). Schuengel et al. (1999) have demonstrated that a loss of parental emotional containment* (via marital discord, parental mental health problems or parental 'insensitivity'), rather than actual bereavement may be the more significant predisposing factor in attachment disturbance. This supports theories of earlier psychoanalysts such as Bion (1962) on the importance of 'maternal reverie*' and parental emotional availability.

1.7.2 "Ghosts in the nursery": The intergenerational transmission of attachment disturbance

There is a danger that Attachment Theory with its emphasis upon parental behaviours can be characterised as unhelpfully parent-blaming. This is something Bowlby was keen to avoid (e.g. 1988). In 1975, Fraiberg, Adelson and Shapiro produced a pioneering paper, warmly recommended by Bowlby, providing a moving plea for help for parents. The "ghosts" are the pain and suffering that an adult (now a parent) experienced in her (or his) own childhood as a

result of insecure or broken attachments. This pain is often excluded from conscious recall in the present, but the defensive mechanisms protecting the individual influence negatively her behaviour towards her own children.

There is indeed increasing evidence of an association between the way in which a mother recalls her own childhood experience and the quality of the relationship existing between her and her own child (Fonagy, Steele and Steele, 1991; van IJzendoorn and Bakermans-Kranenburg, 1996). Use of longitudinal studies and the development of the Adult Attachment Interview (George et al., 1985) have succeeded in demonstrating empirically how early attachment styles are stable over time and can be passed on through generations of families (Main 1991; van IJzendoorn, 1995). Such evidence supports Bowlby's thesis of an Internal Working Model (Bowlby, 1977). The unconscious transgenerational transmission of attachment style is thought to be one of the key areas for further research in this field (Ward et al., 2000).

1.8 The present study

1.8.1 Rationale for the study

Using the conceptual frameworks provided by "Control Theory" (Kobak et al., 1993) and "Dynamic Maturational Theory" (Crittenden, 1997a, b) it has been argued that adolescents presenting with eating disorders and clinical depression may be expected to exhibit different attachment styles: the former demonstrating a more deactivating pattern, the latter a more hyperactivating one (Cole-Dekte and Kobak, 1996) and that both styles may develop as a result of 'dissociative' information processing acting as a defence against early traumatic experiences with caregivers (Crittenden, 1997 a, b). It is hypothesised that an eating disordered group is serving to defend against depression by avoiding a focus on attachment relationships (Williams, 1997), whilst a depressed group is excessively preoccupied with these insecure relationships and unable to detach from them (Richter, 1994).

The areas examined by the present paper will be necessarily selective. In line with the above review, particular attention will be paid to an examination of whether insecure attachments,

across a number of domains, are indeed reported by adolescent girls with eating disorders and clinical depression. Further examination will be given to whether there are correlations between parent and adolescent data in light of theories of intergenerational attachment transmission. Also of interest will be the cognitive strategies and reflective capacity evidenced in clinical groups (following Kobak and Cole, 1994; Cole-Dekte and Kobak, 1996 and Crittenden 1997 a, b). Finally, there will be investigation of the number of known/reported incidents of abuse, maltreatment and frightening parental behaviour in the histories of clinical adolescents, following the substantive literature pertaining to these being significant factors in the aetiology, particularly, of adolescent depression.

1.8.2 Research Hypotheses (Quantitative analysis)

Based upon the existing literature this study will pose six principal hypotheses in relation to the perceived attachments of adolescent girls and their parents:

- **Hypothesis 1: Clinical adolescents and symptomatology:**

Clinical adolescents will show clear evidence of symptomatology on three administered symptom measures (the Beck Depression Inventory II (BDI II), Stirling Eating Disorder Scales (SEDS) and Youth Self Report (YSR)) compared to a control group .

- **Hypothesis 2: Clinical adolescents and insecure attachment**

A. On the Parental Bonding Instrument (PBI), clinical adolescents in both groups will score lower for maternal 'Care' and higher for maternal 'Overprotection' than controls, with a significantly higher incidence of the most pathological bonding type "Affectionless Control" (low care-high overprotection).

B. On the Adult Reciprocal Attachment Questionnaire (ARAQ), clinical adolescents in both groups will score more highly on four pathological attachment 'Patterns' than control group adolescents.

C. i) On the Separation-Individuation Test of Adolescence (SITA), clinical adolescents in

both groups will score more highly on negative dimensions of *Engulfment Anxiety, Separation Anxiety, Rejection Expectancy* and *Dependency Denial* than controls.

ii) Controls will score more highly on positive dimensions of *Practising Mirroring, Nurturance /Caretaker Enmeshment* and *Healthy Separation.*

iii) Girls with eating disorders will score more highly for deactivating dimensions of *Engulfment Anxiety* and *Dependency Denial* than depressed girls, who will score more highly for hyperactivating dimensions of *Separation Anxiety* and *Rejection Expectancy* .

- **Hypothesis 3: Clinical adolescents and impoverished family functioning:**

Girls from both clinical groups will exhibit a higher degree of 'Extreme' family types, of 'Disengaged' family cohesion and 'Rigid' family adaptability on the Family Adaptability and Cohesion Scales II (FACES II) than the control group.

- **Hypothesis 4 : Psychopathology/Symptomatology in parents of clinical adolescents and intergenerational correlations:**

A. Parents of clinical adolescents will show evidence of clinical symptoms according to their self-report data ((Young) Adult Self-Report (YASR) and BDI II), to a greater extent than control parents.

B. Parents of clinical adolescents will show greater evidence of pathological bonding to their own mothers, according to PBI data, compared to control parents.

C. There will be a significant correlation between parental and adolescent scores on common administered measures of symptomatology, family functioning and attachment (PBI, ARAQ, FACES II, BDI II and YSR/YASR scores)

- **Hypothesis 5: Attachment style and clinical diagnosis:**

Eating disordered adolescents will display the lowest levels of reflective functioning (on the Reflective Functioning Scale: Fonagy et al., 1997) within their attachment interviews, with greater instances of 'disavowal' (a deactivating strategy) than other groups. Depressed

adolescents will also show lower levels of reflective functioning ability than controls, but with greater instances of over-analytical strategies (hyperactivation).

- **Hypothesis 6 : Childhood maltreatment /parental 'frightening behaviour' and adolescent psychopathology:**

There will be a significantly higher number of reported or known incidents of maltreatment and/or parental 'frightening behaviour' revealed in attachment interviews, questionnaires and/or clinical notes (including sexual, physical and emotional abuse) in the two clinical samples, compared to the control sample.

1.8.3 Research Questions (Qualitative analysis)

Attachment interview data will also be analysed qualitatively according to the following questions:

- How do adolescents within and across the three groups (Eating Disordered, Depressed and Control) describe their early attachments to parents and significant others? What themes best describe these relationships?

- What are the differences and similarities between the three groups in terms of themes generated?

- What themes are distinct to the clinical groups alone? How do they differ from controls?

- What themes are distinct to the Eating Disordered Group alone?

- What themes are distinct to the Depressed group alone?

CHAPTER 2: METHODS

A mixed methodology was selected, with quantitative analysis of self-report questionnaires combined with both qualitative and quantitative analyses of attachment interviews. The rationale for the choice of methodology was fourfold:

- The predominantly quantitative nature of previous research in the area to which this study aimed to contribute (O'Kearney 1996; Ward et al., 2000).

- The generation of clear hypotheses by the researcher, based on evaluation of previous literature.

- A notable lack of qualitative research in the area which this study aimed to address.

- Problematic aspects of relying upon self-report measures with these clinical populations, which interview data aimed to counteract.

2.1 DESIGN

A between-group comparative paradigm was used, although both between and within-group differences were examined. Three groups were studied:

Group 1: Adolescent girls with a diagnosed eating disorder (anorexia or bulimia nervosa) and their parent (s).

Group 2: A clinical comparison group of clinically depressed adolescent girls and their parent (s).

Group 3: A control group of adolescent girls and their parent (s).

The rationale for recruiting only girls was that the vast majority of adolescents exhibiting eating disorders and depression are female (Steinberg, 1994) and in an attempt to avoid gender confounds

(Cole and Kobak, 1991).

The decision to involve parents was reached from a number of studies indicating a gap in existing research literature pertaining to intergenerational attachment (Burbach, Kashani and Rosenberg, 1989) and from the convincing theoretical and research literature indicating its relevance to adolescent pathology (Fonagy et al., 1991).

2.2 PARTICIPANTS: Selection and characteristics

Ten adolescent girls and their consenting parent(s) were recruited into each of the three groups. The girls had to be aged between thirteen and twenty one, as this is the age-band defined as "adolescent" in much psychoanalytic literature (e.g. Laufer 1997) and in an attempt to isolate an adolescent-onset eating disordered group (Dare, Eisler, Russell and Szmukler, 1990), the failure to do so being a criticism levelled at earlier studies (Ward et al., 2000).

A total of thirty adolescents and thirty parents were recruited. It was acknowledged that the adolescent sample (10 per group) was too small to ensure an adequate level of statistical power and exclude making a Type II error (eta squared of 0.138, Clark-Carter, 1997). For this, there should have been at least twenty participants in each group (Clark-Carter, 1997, p. 627). This was not possible due to the time constraints of this study and recruitment difficulties.

Adolescents for the two clinical groups were recruited from clinics in London and the Home Counties: two specialist eating disorders services, an outpatient adolescent service and four child and adolescent mental health service (CAMHS) teams. Two clinical participants were recruited through schools, having volunteered for the control group. Both were in treatment and consent was gained for their participation from relevant clinical teams. Within the Eating Disordered group, all girls met DSM-IV criteria for Anorexia Nervosa, Bulimia Nervosa or "mixed" typology (DSM-IV, American Psychiatric Association, 1994). Within the Depressed group, all girls met DSM-IV criteria for Unipolar Depression (DSM-IV, 1994). Diagnoses were determined by

referral letter and assessment by the clinical team.

All girls also completed the BDI II and Stirling Eating Disorder Scales to determine inclusion in the relevant group. Girls were not excluded if they did not score clinically on the relevant measure but met all other inclusion criteria. All girls in both clinical groups were currently undergoing assessment or treatment. All were outpatients, although three girls in the Eating Disordered group underwent regular periods of hospital admission. All clinical participants were within the first six months of their current treatment regime, although two eating disordered girls and four depressed had also received help in the past.

The control group were recruited from three different schools, in the hope of mirroring diversity within the clinical groups:

School A – was a selective Girls' Grammar School in an affluent area of the Home Counties.

School B – was a mixed comprehensive in the same area as school A.

School C - was a mixed comprehensive in a less affluent area.

Six control participants came from School A, one from School B and three from School C. A total of twenty one girls overall, across the three schools, volunteered for the control group. Eleven of these were excluded due to presentation on screening questionnaires of significant clinical symptoms (six depression, three eating disorders, one thought disorder, one multiple). All bar one of these were from School A, although this school also had by far the largest response rate (N=16).

For inclusion in group 3, control participants needed to score non-clinically for eating disorders and depression and to have no history of contact with mental health services. Depressed group participants needed to score as non-clinical for eating disorders. Due to high co-morbidity between eating disorders and clinical depression (O'Kearney et al. 1995), it was acknowledged that some eating disordered participants would also have high depression levels. It was,

nonetheless felt important to include these girls, in order to differentiate between depressed adolescents without eating disorder pathology and an eating disordered group, in order to explore any emergent differences between attachment profiles and address current research gaps comparing clinical populations (O'Kearney 1996). To have excluded this comorbid group would also have made recruitment difficult and distorted the clinical picture (Ward et al., 2000).

Demographic information is shown in Table 1 (below). It can be seen that the ages of participants in the study actually ranged from thirteen to nineteen and that the majority were white. The overall mean age of participants was 15.77 years (standard deviation, 1.63). Of the participants who met DSM-IV criteria for eating disorders, four were anorexic, four bulimic and two exhibited "mixed" typology.

Demographic information was obtained from participants. Permission was also sought from clinical participants for the researcher to consult with their clinician and clinical notes for further background information. This was gained in all but two cases. Consultation took place after questionnaires and interviews were completed and analysed to avoid influencing the researcher's interpretation of these data.

Table 1 – Participant profile (for full profiles of each participant see Appendix 1)

Group	Age Range	Region	Ethnicity	Parental occupations	Recruitment Source	Mean length of contact with services (clinical groups)
1. Eating Disordered (N = 10)	13-19 Mean 15.9 (SD 1.97)	6 - HC 3 - IL 1 - OL	10 – White	15 – Professional # 3–Semi-Professional/ Manual # 2 – At home/not working	4 – Adolescent O/P service 2 – CAMHS teams 3 – Eating Disorders' services 1 – School	3.2 months
2. Depressed (N = 10)	13-19 Mean 16.2 (SD 1.75)	4 – HC 5 – IL 1 – OL	7 – White 2 – Indian 1 - Israeli	8 – Professional 8–Semi-Professional/ Manual 4– At home/not working	6 – Adolescent O/P service 1 – School 3- CAMHS teams	3.4 months
3. Control (N = 10)	14-17 Mean 15.2 (SD 1.03)	8 – HC 2 - OL	9 – White 1 – South American	17 – Professional 2–At home/not working (1 parent dead)	Schools: 6 – School A 1 – School B 3 – School C	N/A

KEY:

= For classification of professional, semi-professional and manual occupations please see Appendix 1

SD = Standard Deviation (this abbreviation will be applied to all subsequent tables)

Regions:

HC = Home counties
IL = Inner London
OL = Outer London

2.3 MEASURES

2.3.1 Symptom/screening measures

The following symptom measures were administered to all potential adolescent participants, partly to determine their inclusion/exclusion. They also provided measurements of current symptomatology.

- **<u>The Stirling Eating Disorder Scale (SEDS) (Williams and Power 1996</u> - Appendix 2)** *Adolescents only*

This 80-item self-report measure of eating pathology has good reliability and validity and has been well standardised (Williams and Power, 1996). Eating Disordered norms were derived from an inpatient population with anorexia or bulimia nervosa and controls were university students and members of the public matched for age (mean age for total sample = 24.5, Williams and Power, 1996).

The measure contains four scales of eating pathology and four cognitive/emotional scales and yields a total score and eight subscale scores for: Low Assertiveness, Low Self-Esteem, Self-directed Hostility, Perceived External Control, Anorexic Dietary Cognitions, Anorexic Dietary Behaviours, Bulimic Dietary Cognitions and Bulimic Dietary Behaviours. Clinical cut-off scores used were those recommended by Williams and Power (1996) (Appendix 2b) .

- **<u>The Beck Depression Inventory II (BDI II) (Beck, Steer and Brown 1996)</u>** *Adolescents and Parents*

The BDI is a 21-item self-report measure of depression intensity, with the total score representing a combination of the number of symptom categories endorsed and severity of particular symptoms. It possesses high internal consistency and discriminant validity (Beck, 1967; Beck, Steer and Garbin, 1988) and has been shown in both clinical and control samples to possess high convergent validity with psychiatric ratings of depression severity (Bumberry, Oliver and McClure, 1978). The BDI is a sensitive screening device for current symptomatology, producing few false negatives when compared with DSM affective disorder diagnoses (Oliver and Simmons, 1984).

The BDI II represents the most recent version of the measure (Beck et al., 1996). Like its predecessor, it has excellent documented reliability and validity (Beck et al, 1996). The BDI II yields a maximum score for depression of 63, with 14 representing the cut-off for mild clinical

depression, 20 for moderate and 29 for severe (Beck et al., 1996). Although depression measures exist more suitable for a younger age-group (e.g. Kovacs, 1978), the BDI II is more methodologically robust and widely used and has been employed in previous studies with clinical adolescents (e.g. Cole-Dekte and Kobak, 1996). This measure is not appended as it is so widely known.

- **The Youth and (Young) Adult Self-Report Forms (Achenbach, 1991, 1997 – Appendices 3 & 4)**

All participants were also administered two modified versions of the Child Behaviour Checklist (CBCL) developed by Achenbach and Edelbrock (e.g. 1987) and adapted for adolescents and adults respectively.

The Youth Self Report (YSR) (Achenbach, 1991) *Adolescents only*

This symptom measure was designed for adolescents of 11-18 years and seeks to obtain views of individuals' competencies and problems in a standardised format. Young people provide self' ratings for twenty competence items and one hundred and two problem items. The measure has excellent reliability and validity (Achenbach, 1991) and has been widely utilised in previous studies of adolescent psychopathology (Adam, Sheldon-Keller and West, 1996; Scott-Brown, 1999). For the syndrome scales, a (total) 'T'-score of 67 (the 95th percentile) is normally considered to mark the cut-off between normal and clinical ranges (Achenbach and Edelbrock, 1987). The syndromes have also been banded together so that 'Internalising' problems (Withdrawn behaviour, Somatisation and Anxiety/Depression) and 'Externalising' ones (Aggression and Delinquency) can be calculated. Norms exist for these scales and the clinical cut-off is 60.

The (Young) Adult Self-Report Form (YASR) (Achenbach 1997) *Parents only*

The problem scales only of the YASR were also administered to all participating parents to gain a measure of parental pathology. Like the YSR, the YASR is well standardised (Achenbach, 1997).

It yields a maximum total problem score of 222, with a clinical cut-off of 67. Although standardised on a younger adult population (aged 18-27 – Achenbach, 1997), all problem items are applicable to adults of any age and an advantage of its use lay in the direct comparison with Adolescent YSR problem scale items.

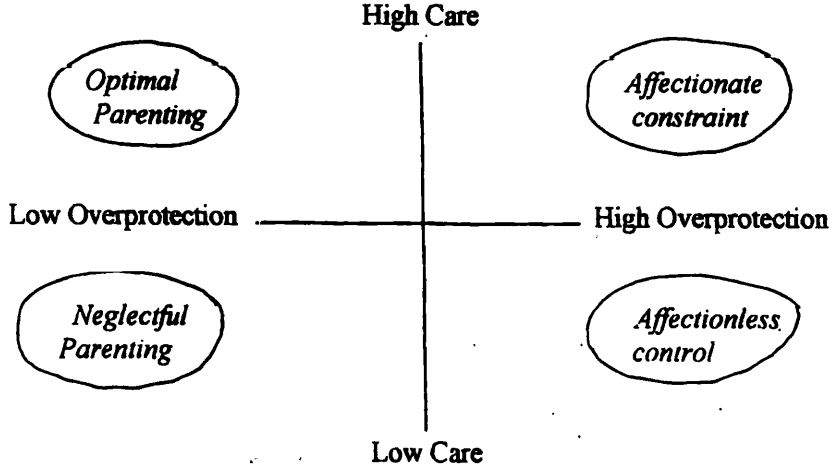
2.3.2 Measures of attachment/ family functioning

- **The Parental Bonding Instrument (PBI) (Parker, et al., 1979 - Appendix 5)** *Adolescents and Parents*

This self-rating instrument designed by Parker (Parker et al, 1979) assesses the participant's recollections of relationships with both parents during the first sixteen years. Its use within the current study was restricted to mothers (one administration only), due to the large number of other measures used.

The participant has to judge their parent's behaviour and attitude as described in 25 items (e.g. "My parents seemed very cold to me") rated on a 4-point Likert-type scale (0 = very like my parents, 3 = very unlike my parents). The measure has established norms and demonstrated reliability and validity (Parker et al., 1979; Wilhelm and Parker, 1990) and is used to assess two major dimensions of parental bonding: **parental care** and **parental over-protection**. Parker (1979b, 1993) suggested using the care and overprotection scales to define four quadrants of parenting style by intersecting both scales at their means using normative data, as shown in Figure 1 (below).

Figure 1: The four quadrants of parenting style from the PBI (from Biggam and Power, 1998).



Most recent studies of adolescent bonding have used norms suggested by Cubis et al. (1989) (maternal care = 24.76; maternal overprotection = 14.55). These were used as clinical cut-offs here. The PBI has norms for both child and adult samples.

- **The Separation-Individuation Test of Adolescence (SITA) (Levine, Green and Millon, 1986 – Appendix 6)** *Adolescents only*

This self-report measure of connectedness and separateness consists of 103 items to which participants respond using a 5-point Likert scale. It was chosen over and above other similar measures (e.g. the Separation Anxiety Test: Hansburg, 1980) due to greater documentation of its psychometric properties and wider use with clinical samples (Rice, Cole and Lapsley, 1990; Levine and Saintonge, 1993).

The instrument has seven scales: *Healthy Separation*; *Nurturance/Caretaker Enmeshment*, *Engulfment Anxiety*, *Separation Anxiety*, *Practising Mirroring* (self-centredness), *Rejection Expectancy* and *Dependency Denial* Three SITA scales: Healthy Separation, Nurturance / Caretaker Enmeshment and Practising Mirroring assess essentially supportive forms of relationships (although the *Nurturance* scale measures both closeness and enmeshment). The four remaining scales assess non-supportive relationships (Quintana and Kerr, 1993).

Due to the length and complexity of this measure and the large number of sub-dimensions within it, the SITA was abbreviated by removing the additional (and less relevant to this study) dimensions of *Teacher* and *Peer Enmeshment*. This reduced the length of the measure to 74 items.

- **The Adult Reciprocal Attachment Questionnaire (West and Sheldon, 1988) (Appendix 7)** *Adolescents and parents*

This 43 item self-report measure of current attachment consists of statements concerning the respondent's relationship with their defined current attachment figure, who is the 'person the respondent is most likely to be living with or romantically involved with; the person that they would most likely turn to for comfort and support; the person that they would be most likely to

depend on and who may depend on them'. Each item is rated on a five-point response scale, ranging from 'strongly disagree' to strongly agree'.

The questionnaire is scored along five *dimensional* scales, each represented by three items and by four *patterned* scales, each represented by seven items. The patterns (examined in this study) are: Angry Withdrawal, Compulsive Self-Reliance, Compulsive Care-Giving and Compulsive Care-Seeking which compare directly with Bowlby's original conceptualisations of insecure attachment typologies (Bowlby, 1977).

Strengths of this measure lie in its good reliability and validity (West and Sheldon-Keller, 1994). There are currently no normative scores for these scales, although they have been used to profile individual patients and in comparative analyses of clinical groups (West and Sheldon-Keller, 1994). Further strengths rest in the measure's emphasis on current relationships, rapidity and ease of administration and close theoretical links with Bowlby's original concepts.

The measure was developed for a clinical, adult population. This, however, makes it suited for use with parents and it was easily adapted by the researcher for applicability to adolescents by substituting the emphasis on selecting a romantic relationship, to selecting a relationship "*with a parent, partner or special friend*". Whilst the implications of this for the reliability and validity of the measure are acknowledged, the change is minimal and in no way alters the substantive content.

- **The Family Adaptability and Cohesion Scales II (FACES II – Olson, Portner and Bell, 1982) (Appendix 8)** *Adolescents and parents*

This self-report measure is rooted in systems theory, particularly Olson's 'Circumplex Model' (Olson, 1986, 1989 – Appendix 9). Its inclusion addresses the possible importance of wider family dynamics to attachment style formation (Palazzoli, 1974; Dallos, 1991). The Circumplex model classifies family functioning into four quadrants along dimensions of 'Cohesion' and 'Adaptability'. The central aspects of 'Cohesion' (**separated** and **connected**) make for optimal family functioning. The extremes (**disengaged** or **enmeshed**) are generally seen as problematic.

The FACES II invites individual family members to describe their life together along these two dimensions of adaptability and cohesion. 'Cohesion' is the degree of bonding that family members have with one another. 'Adaptability' indicates the ability of a family to change its power structures, rules and roles in response to stressful situations. The questionnaire consists of 30 items, rated using a 5-point Likert rating scale. The measure yields three scores per respondent: a 'Cohesion' score (maximum 80, minimum 1), an 'Adaptability' score (maximum 70, minimum 1) and an overall score of family 'Typology' (maximum 8, minimum 1).

The FACES II has good reliability and validity and has been used in a wide range of previous studies of family functioning (e.g. Olson, Russell and Sprenkle, 1983). Although a revised edition of this measure is also in existence (FACES III – Olson, Portner and Lavee, 1985) the earlier measure was chosen due to its comparative brevity and ease of administration and as existing studies do not convincingly demonstrate the superiority of the revised measure (Olson, 1986).

- **The Attachment Interview (Appendix 10)**

The aim of the attachment interview was to elicit a narrative about adolescents' perceptions of their early attachment experiences with parents and others. A series of questions was designed to form a semi-structured interview, based closely upon the Adult Attachment Interview Protocol devised by George et al (1985).

- Developing the Interview Protocol

Like the AAI, the interview asked questions about early relationships with mother and father and asked respondents to think of five adjectives/words to describe their relationship with each parent. Adolescents were next asked about separation experiences, traumatic incidents and important losses. In addition and unlike the AAI, they were asked about current relationships to peers and romantic relationships. Finally adolescents were asked to imagine themselves as parents and what their hypothesised child might learn from them. Reliability and validity of the protocol were assumed to be good, due to its close similarities with the highly robust AAI. The protocol was

checked, however, by two independent clinical psychologist colleagues for face validity.

- Piloting the interview

Four pilots of the interview schedule were undertaken: two with adults, one with a history of eating disorders and one with a history of depression and two with adolescents from a control population. All were asked to comment on the interview, its delivery and questions. Feedback was incorporated to ensure sensitive questioning and adequate debrief. The researcher was also interviewed using the schedule by a professional colleague, to develop further insight into the participant experience.

- Recruitment for interview

Adolescents were asked on their initial consent form if they agreed to be interviewed. All bar two who completed questionnaires gave consent. Participants were selected randomly for interview, within two constraints:

- It was endeavoured to match interviewees for age as much as possible and to include a range of ages.

- With the eating disordered group, two interviewees were selected who had no concomitant depression and three were selected with significant comorbid depression, to examine any differences in accounts. It is acknowledged that this balance does not accurately reflect the larger number of non-comorbid eating disordered girls in the quantitative study.

- Coding the Interviews

The interviews were scored for Reflective Function (RF), a concept described previously ('Introduction', page 5). RF ratings (Fonagy et al, 1997) are based on a manual (Appendix 11: extract) and both test-retest and inter-rater reliabilities are good (Fonagy, Steele, Steele, Higgitt and Target, 1994). RF is scored from 1 to 9, with 1 representing total lack of reflexivity and 9

exceptional RF. At the top end of the scale (scores 7-9) are individuals whose narratives represent a coherent mental representation of the psychological world of their current and past attachments. Poor reflective function (scores 1-3) is deduced when the narrative does not include references to mental states or does so in platitudinous terms (Fonagy et al., 1994). A randomised sample of six transcripts were blind coded by an independent rater for inter-rater reliability.

2.3.3. Summary of Measures

The following measures were therefore administered (and yielded) :

Symptom Measures:

- **The Stirling Eating Disorder Scale** (Williams and Power, 1996) (total score of eating pathology, anorexic and bulimic cognitions and behaviours).

- **The Beck Depression Inventory II #** (Beck et al, 1996) (total depression score and mood status: severe, moderate, mild or non-depressed).

- **The Youth/Young Adult Self-Report #** (Achenbach, 1991/ 1997) (total symptom score, clinical/non-clinical status, externalising/internalising score).

Attachment measures:

- **The Parental Bonding Instrument #** (Parker et al, 1979) (maternal 'care' and 'overprotection' score and bonding type).

- **The Adult Reciprocal Attachment Questionnaire #** (West and Sheldon, 1988) (scores for 'compulsive care-giving', 'compulsive care-seeking', 'compulsive self-reliance' and 'angry withdrawal').

- **The Separation-Individuation Test of Adolescence** (Levine, Green and Millon, 1986) (scores for 'engulfment anxiety', 'dependency denial', 'nurturance/enmeshment', separation anxiety', 'practising mirroring', 'healthy separation' and 'rejection expectancy').

- **The Family Adaptability and Cohesion Scales II #** (Olson, Portner and Bell, 1982) (family 'cohesion' and 'adaptability' scores and overall 'family typology' score).

The following measure was additionally administered to five adolescents per group who had agreed to be interviewed:

- **Attachment Interview** (data analysed quantitatively using the Reflective Functioning Scale (Fonagy et al, 1997))

(# denotes administered to both adolescents and parents)

2.4 PROCEDURE

2.4.1 Ethical approval

Ethical approval was sought from relevant NHS Trust Ethical and Research and Development committees (Appendix 12) and from the relevant education authority for the non-clinical group (Appendix 13). All approval was forthcoming, the former with the proviso that some minor changes were made to the Information Sheet for participants (Appendix 12). These were duly made and full approval granted. Informal approval was also sought and gained from all clinical directors and teams for the clinical groups and from school headteachers and teaching staff for the control group.

2.4.2 Participant information

All potential participants who agreed to being approached were initially provided with an information sheet about the study via their clinician or school (Appendix 14). The information sheet explained:

- The nature and purpose of the research

- What was expected of participants
- Confidentiality
- The participant's right to withdraw at any time
- The fact that the decision to refuse or terminate involvement would not affect treatment received (groups 1 and 2).

2.4.3 Gaining informed consent

A standard consent form was devised for all participants (Appendix 15). This was completed by participants once the researcher and clinician, for the clinical samples, were satisfied that the participant had made an informed decision about participation. The researcher ensured that informed verbal consent was obtained from interviewees before interviews commenced. For all participants under sixteen written parental consent for their participation was gained.

2.4.4. Recruitment

Potential clinical participants were identified by clinician assessment and referral letter. For groups 1 and 2, clinicians obtained consent from their clients for either just themselves or themselves and their parents to be contacted by the researcher. It was explained to all under sixteens that their parents would need to give consent for their involvement, even if not participating themselves. Those who consented were initially contacted by letter (addressed to the adolescent and their parents) enclosing the information sheet and consent forms to complete and return. Those who opted in were contacted by telephone to ensure they fully understood what was required and for the researcher to answer any questions. Participating adolescents and parents were then sent questionnaires pack by post (due to time constraints), with an instruction sheet (Appendix 16). Questionnaires were completed by participants independently and returned confidentially in a pre-paid envelope. Those who agreed to interview were subsequently contacted to arrange this. In all cases bar one, interviews took place at the clinic where the young person

was being seen.

For controls, initial contact was made, with the full consent and participation of schools, via a letter home to parents and girls in Year 9 and above (Appendix 17). This asked girls to express an interest in participating by returning a slip to school. Those who did so were sent information sheets and consent forms. Due to time factors, personal contact was not made with controls prior to sending out questionnaires.

Written consent for participation was thus obtained from the adolescent and their parent/guardian (if participating or the adolescent was under sixteen) with verbal consent from the allocated clinician (clinical groups) and schools (control group).

As clinical participants were carefully selected, none were excluded from the study having been approached. The eleven potential controls, excluded due to meeting clinical criteria, were contacted confidentially and a meeting offered with the researcher to discuss further help. Six adolescents took up this offer of a meeting. Only one asked to be referred for further help and contact was made with her G.P. The other five did not consent to referral for further help, but were provided with information about sources of help available. Confidentiality was to be respected with the exception of adolescents whom the researcher deemed to be in danger of causing significant harm to themselves or others. No adolescents fell into this category.

2.4.5 Administering the Attachment Interviews

A smaller sub-sample of 5 adolescents per group were seen for interview. This was undertaken using the interview schedule devised by the researcher, based upon the AAI (George et al., 1985). All interviews were conducted by the researcher in a private room and lasted from 50 to 90 minutes, with most lasting approximately 75 minutes. All were tape-recorded, with the exception of one, where the adolescent refused to be taped, despite assurances of confidentiality. Her answers were written down verbatim.

2.4.6 Debriefing procedures

At the end of the study, debriefing procedures were in place as follows:

- For participants who had completed questionnaires only, a follow-up telephone call was made by the researcher, with participants' consent, to ask for feedback and offer support if necessary.

- For participants also being interviewed, the above was offered, together with a full debrief following the interview (Appendix 18).

- It was ensured that all adolescent participants had access to a named person whom they could contact should the experience of participation cause them distress.

- A contact number for the researcher was also provided so that participants could make contact should issues arise subsequently.

- All control participants were provided with information about sources of further help locally.

- All participants were written to by the researcher at the end of the study and thanked for their participation.

2.5 SCORING AND DATA MANAGEMENT

Questionnaires and Attachment Interview transcripts were all scored by the researcher.

Quantitative questionnaire data were analysed using the SPSS for Windows computer package version 7.5 (Norusis, 1996). Although group sizes were relatively small, parametric tests were employed for between-group adolescent data, given that two out of three necessary parameters were fulfilled (normal distribution and homogeneity of variance, Greene and D'Oliveira, 1982). This allowed a more powerful test to be applied. The most common test selected was a one-way ANOVA for unrelated designs, due to the presence of three groups of different participants. A

post-hoc Scheffe test was used to determine specific between-group differences (Everitt, 1996). Within-group, reflective functioning and parental data analysis was, however, undertaken using non-parametric tests (Kruskal Wallis and Mann Whitney) due to unequal and/or small group sizes.

All attachment interviews (N=15) were transcribed verbatim by the researcher. Interview data were then analysed using the Reflective Functioning Scale (Fonagy et al., 1997, Appendix 11) and classified according to whether it was felt the interviewee had experienced childhood maltreatment under the following headings: 'physical abuse', 'sexual abuse', 'emotional abuse', 'neglect' and 'parental frightening behaviour'. The latter was defined, in line with current research (Main and Hesse, 1990; Schuengel et al., 1999) as "an unresolved, unpredictable episode of parental behaviour that the child does not know how to interpret and of which the child may feel the cause" (van IJzendoorn, 2000). Ratings of maltreatment were cross-checked by two independent raters, one a trainee clinical psychologist and one an assistant psychologist.

Interview data were also analysed qualitatively using an approach based on Interpretative Phenomenological Analysis (IPA) (e.g. Smith, Flowers and Osborn, 1997), as further interest lay in participants' detailed descriptions of their attachments. IPA represents: "An attempt to understand how participants themselves make sense of their experiences" (Smith 1996, 1999). It does not represent a single truth, but rather a "co-product between researcher and researched where both parties are required" (Smith, 1999). IPA borrows much from Grounded Theory (Charmaz 1995; Strauss and Corbin, 1990, 1994) and, like this and other qualitative methods, is based around a systematic search for themes and resultant superordinate concepts. Unlike Grounded Theory, however, IPA conceptualises research as more of a dynamic process (Smith, 1996), allowing for researcher bias and incorporating the researcher as an active participant. For these reasons it was selected here in preference to Grounded Theory.

Following the protocol for this analysis provided by Osborn and Smith (1998), each transcript was read several times by the researcher. Notes were made in the left-hand margin of phrases that

seemed to indicate first-order themes for that transcript. Secondly, a note was made in the right hand margin of each transcript of any second-order / meta-themes that might be suggested by the initial categories. The process was repeated for all transcripts within each of the three groups and lists of second-order themes were compared within and across groups to highlight common overarching themes (i.e. those shared by two or more interviewees). A full IPA analysis (e.g. comprising feedback of themes to participants) was not carried out, due to time constraints and the mixed methodology of this study.

In order to assess inter-rater reliability of generated IPA themes, a consultant clinical psychologist, working with adolescents and with considerable experience of IPA, rated the validity of researcher-generated themes in six transcripts, two from each group, selected randomly within groups. For two transcripts, researcher and inter-rater categorised themes independently and compared analyses in detail. Themes for the remainder (four) transcripts were crosschecked by the inter-rater using a 5-point rating scale devised by the researcher (Appendix 19). This method of inter-rating was chosen above the more usual method of blind-classifying themes into superordinate categories, as the latter method was felt by researcher and inter-rater to be unhelpful for this sort of analysis as it divorced themes from their context. The former procedure of blind-rating and detailed discussion ensured that a shared understanding was reached about procedures of theme generation and clustering.

CHAPTER 3: RESULTS

3.1 Quantitative Results

Within this section each hypothesis will be addressed in turn. For details of hypotheses, please see 'Introduction' section, pages 12 -14. Within this section, $p<.05$ will be adopted as the level of significance and significance levels of .05 to .08 will be treated as statistical trends.

3.1.1. Hypothesis 1: Clinical adolescents and symptomatology:

Mean symptom scores and standard deviations for each group are shown in Table 2 (below).

Table 2: Mean symptom scores and statistical analyses on the YSR, BDI II and SEDS across the three groups of adolescents

Group	YSR score / level	BDI II score / level	SEDS score / level
1. Eating Disordered (N = 10)	73.2 (SD 27.72) clinical range	24.5 (SD 14.59) moderate	173.0 (SD 50.04) clinical
2. Depressed (N = 10)	88.5 (SD 24.62) clinical range	24.5 (SD 12.49) moderate	86.06 (SD 19.37) non-clinical*
3. Control (N = 10)	48.5 (SD15.93) normal range	8.9 (SD 3.07) not depressed	55.13 (SD 34.37) non-clinical
	ANOVA F = 7.505 df = 2 p=.003 *** (two-tailed) Scheffe: 2&3 p=.003 ** Mean diff. signif. at p<.05 *	ANOVA F = 6.435 df = 2 p=.005 *** (two-tailed) Scheffe:2-3,1-3 p=.016 * Mean diff signif. at p<.05 *	ANOVA F = 27.59 df = 2 p=.000 *** (two-tailed) Scheffe:1-2,1-3 p=.000*** Mean diff. signif. at p<.05 *

KEY :

df = degrees of freedom (this abbreviation will be applied to all subsequent tables in this section)

*** = significant at p=.001 (highest significance level)
** = significant at p=.01
* = significant at p=.05

(these designations of significance levels will be applied to all subsequent tables in this section)

As can be seen from Table 2 , the mean difference between the three sets of symptom scores was statistically significant ($p<.05$, two-tailed), with clinical adolescents achieving more

severe (higher) scores. This supported the hypothesis that clinical adolescents would show evidence of greater symptomatology than controls. The depressed group was more severe on overall symptoms (YSR) than the eating disordered group whose scores were not significantly different from controls.

There was a further significant difference in scores within the two groups, not predicted in the original hypotheses. Within the eating disordered group, girls with comorbid depression (N = 4) achieved significantly more severe scores, using a Mann Whitney test, on the YSR (U=2, p=.038*) and, unsurprisingly, on the BDI II (U= .000, p=.01**). There was also a statistical trend towards this group achieving more severe scores on the SEDS than their non-depressed counterparts (U = 3, p=.067). Within the depressed group there were no such significant within-group differences, although there was a statistical trend, using Mann Whitney, for girls with moderate or severe depression levels on the BDI II to also achieve significantly higher overall symptom scores on the YSR (U=3, p=.056) than those with mild depression.

3.1.2 Hypothesis 2: Clinical adolescents and insecure attachment:

Tables 3, 4 and 5 (below, next page) show mean scores and profiles obtained by the three groups of adolescents on the PBI, ARAQ and SITA measures and analysis of these results using one-way ANOVA.

2A. Maternal Bonding

On the PBI, It can be seen from Table 3 (below) that the difference in 'care' and 'overprotection' scores was significant between the three groups at $p < .05$. Clinical adolescents in both groups scored more highly for non-optimal bonding types: "Affectionate Constraint" (N= 5), "Neglectful" (N=3) and the most pathological type "Affectionless Control" (low care-high overprotection) (N = 8) thus supporting Hypothesis 2A. Girls with depression had the lowest 'care' scores but normal 'overprotection' scores, whereas those with eating disorders had the highest 'overprotection' scores and normative 'care' scores.

Table 3 : Statistical analysis of adolescents' scores on the Parental Bonding Instrument (PBI)

PARENTAL BONDING INSTRUMENT (PBI)			
Group	**Mean 'care' score (SD)**	**Mean 'overprotection' score (SD)**	**Most common bonding type**
1. Eating Disorder (N = 10)	23.9 (SD 9.16)	16.9 (SD 6.94)	Affectionate constraint (N=5)
2. Depression (N = 10)	21.1 (SD 7.59)	14.7 (SD 6.48)	Affectionless control (N = 5)
3. Control (N = 10)	30.4 (SD 5.50)	9.4 (SD 5.76)	Optimal (N = 8)
	ANOVA: F = 3.975 df = 2 p =.031* (two-tailed) Scheffe: 2&3 p=.036 * - signif. at the .05 level	ANOVA: F = 3.617 df = 2 p = .041* (two-tailed) Scheffe: 1&3 P=.041 * - signif. at the .05 level	

There was a statistical trend (p=.067 on a Mann Whitney test) for the depressed sub-group of eating disordered participants to have lower 'care' scores (mean = 17.75, SD = 7.54) than the non-depressed sub-group (mean = 28, SD = 8.15). There was no such within-group variation within the depressed group.

2B. Current Attachment

Table 4 : Statistical analysis of adolescents' scores on the Adult Reciprocal Attachment Questionnaire (ARAQ)

ADULT RECIPROCAL ATTACHMENT QUESTIONNAIRE (ARAQ)				
Group	**AW (SD)**	**CCG (SD)**	**CSR (SD)**	**CCS (SD)**
1. Eating Dis. (N = 9)	16.11 (SD 5.56)	24.44 (SD 2.46)	17.0 (SD 6.58)	18.44 (SD 7.52)
2. Depressed (N – 10)	15.7 (SD 6.63)	23.2 (SD 4.47)	20.3 (SD 4.32)	16.5 (SD 4.48)
3. Control (N = 10)	13.3 (SD 2.58)	20.8 (SD 3.71)	17.9 (SD 3.07)	17.0 (SD 4.50)
	F = .830 p=.447 Not significant	F = 2.437 P=.107 Not significant	F = 1.219 p= .312 Not significant	F = .304 p=.740 Not significant

KEY:

AW = Angry Withdrawal
CCG = Compulsive Care-giving
CSR = Compulsive Self-Reliance
CCS = Compulsive Care-Seeking

Mean scores obtained by the three groups on the four 'Attachment Patterns' of the ARAQ are shown in Table 4 (above). There were no statistical differences on these patterns between the three groups. Due to the smaller than planned sample size, data were inspected for descriptive trends, which could form the basis of further, more focussed research. According to this, girls with eating disorders reported higher (although non-significant) levels of 'angry withdrawal' and 'compulsive care-giving/compulsive care-seeking' than the depressed group, who reported higher levels of 'compulsive self-reliance'. Within the eating disordered group, comorbid girls showed a more haphazard pattern of scores, whilst girls with eating disorders who were not severely depressed showed a uniform tendency to report highest levels of 'compulsive care-giving/care-seeking'. As these differences were non-significant, however, great care must be taken not to over-emphasise them.

2C Separation-Individuation

Mean scores obtained by the three groups on the SITA dimensions are shown in Table 5 (below). Differences in SITA scores were significant only on two dimensions: 'Nurturance / Caretaker Enmeshment' and 'Rejection Expectancy'. The significance in 'Nurturance' scores was between eating disordered and depressed girls and that in 'Rejection Expectancy' between depressed and controls.

These results do not fully support Hypothesis 2C (above, pages 12-13), although they provide partial support of Hypothesis 2C i) and iii). That depressed girls reported higher 'rejection expectancy' and eating disordered girls higher 'caretaker enmeshment' fits with the PBI profile.

Table 5 : Statistical analysis of adolescents' scores on the Separation-Individuation Test of Adolescence (SITA)

SEPARATION-INDIVIDUATION TEST OF ADOLESCENCE (SITA)							
Group	**Engulfment Anxiety (-ve)**	**Practising Mirroring (+ve)**	**Dependency Denial (-ve)**	**Separation Anx. (-ve)**	**Nurturance/ Caretaker Enmeshment (+ve)**	**Healthy Sep. (+ve)**	**Rejection Expectancy (-ve)**
1. Eating Dis. (N = 9).	31.53 (SD 5.49)	23.12 (SD 4.70)	22.23 (SD 6.86)	30.64 (SD 3.44)	30.93 (SD 4.35)	42.08 (SD 3.79)	27.87 (SD 7.32)
2. Depressed (N = 10)	31.60 (SD 7.57)	27.99 (SD 4.64)	22.47 (SD 4.66)	33.33 (SD 6.35)	24.88 (SD 3.14)	37.01 (SD 5.99)	.93 (SD 6.33)
3.Control (N = 10)	27.28 (SD 7.35)	27.33 (SD 4.27)	20.75 (SD 3.63)	30.06 (SD 5.34)	27.17 (SD 6.45)	40.0 (SD 3.99)	20.92 (SD 4.52)
	ANOVA: F = 1.258 df = 2 P = .301	ANOVA: F = 3.171 df = 2 p = .059	ANOVA: F = .321 df = 2 p = .728	ANOVA: F = 1.098 df = 2 p = .349	ANOVA: F = 3.712 df = 2 p = .038* (two-tailed)	ANOVA: F = 2.777 df = 2 p = .081	ANOVA: F = 5.906 df = 2 p = .008** (two-tailed)
	Not significant	Non-significant trend	Not significant	Not significant	Scheffe: 1&2 p=.040 * (two-tailed) Signif. at the .05 level.	Non-significant Trend	Scheffe: 2&3 p=.011 * (two-tailed) Signif. at the.05 level

KEY

+ve = Positively weighted subscale
-ve = Negatively weighted subscale

3.1.3. Hypothesis 3: Clinical adolescents and impoverished family functioning:

The mean scores for each group of adolescents on the 3 dimensions of the FACES II are shown in Table 6 (below). There were significant between-group differences on the FACES II, thus supporting Hypothesis 3. Depressed adolescents reported significantly higher levels of family pathology (poor cohesion and adaptability) than did controls, although eating disordered families were not reported to be more pathological than controls.

Within the eating disordered group there was a significant difference between scores for 'Adaptability' (p=.038*, two-tailed) and 'Family Type' dimensions (p=.038*, two-tailed), using Mann Whitney and a statistical trend on the 'Cohesion' dimension (p=.067) between comorbid and non-comorbid girls. Those with depression reported more pathological family functioning than did the sub-group without. There was no such variation in scores within the

depressed group. It would seem, therefore, that reported pathological family functioning is directly related only to adolescent depressive symptomatology.

Table 6: Mean scores and significance levels obtained by the three adolescent groups on the FACES II (Olson, Portner and Bell, 1982).

Group	Mean Cohesion Score and type	Mean Adaptability Score and type	Mean Family Type
1. Eating Disordered (N = 10)	49.7 (SD14.04) Disengaged	40.7 (SD9.03) Structured	3.5 (SD 1.90) Mid-range
2. Depressed(N = 10)	44.5 (SD6.92) Disengaged	36.6 (SD 5) Rigid	2.25 (SD 0.83) Extreme
3. Control (N = 10)	60.0 (SD7.64) Connected	46.8 (SD 5.83) Flexible	5.0 (SD1.34) Moderately Balanced
	ANOVA: F=6.071 df=2 p= .007 ** (two-tailed) Scheffe: 2&3, p=.008 Signif. at p<.05 *	ANOVA: F = 5.237 df = 2 p= .005 ** (two-tailed) Scheffe: 2&3, p=.013 Signif. at p<.05 *	ANOVA: F = 6.526 df = 2 p=.012 * (two-tailed) Scheffe: 2&3, p=.005 Signif. at p<.05*

3.1.4. Hypothesis 4: Parental psychopathology/symptomatology and intergenerational correlations:

4A: Parental symptomatology

Table 7 (below) shows mean symptom scores for the three groups of parents on the BDI II and YASR.

Table 7: Mean scores obtained by the three parent groups on two measures of symptomatology (BDI II and YASR)

Parent group	Mean BDI II Score	Mean YASR problem scale score
1. Eating Disordered (N = 7)	9.00 (SD 4.69)	47.14 (SD 23.60)
2. Depressed (N = 8)	5.88 (SD 7.32)	40.00 (SD 22.45)
3. Control (N = 15)	5.73 (SD 6.05)	36.6 (SD 14.14)
	Kruskal Wallis Test: Chi Square = 3.775 Df = 2 P=.151 Not significant	Kruskal Wallis Test: Chi Square = 1.228 df = 2 P=.541 Not significant

Although parents of eating disordered adolescents displayed greater symptomatology than those of depressed or control adolescents and both clinical groups of parents displayed slightly

more severe symptomatology than controls, a Kruskal Wallis test did not produce statistically significant results.

4B: Parental attachments

Past attachments

Table 8 (below) shows mean PBI scores for 'Care' and 'Overprotection' given by parents from the three groups.

Table 8: Mean scores obtained by the three parent groups on the PBI

Parent group	'Care'	'Overprotection'
1. Eating Dis.(N = 7)	24.71 (SD 2.98)	14.86 (SD 6.69)
2. Depressed (N = 8)	31.5 (SD 3.88)	12.75 (SD 6.45)
3. Controls (N = 15)	27.27 (SD 7.57)	13.20 (SD 7.03)
	Kruskal Wallis Test: Chi Square = 6.213 p=.045* (two-tailed) Median = 28.5 Maximum = 36.00 Minimum = 11.00	Kruskal Wallis Test: Chi Square = .715 p=.699 Median = 13.0 Maximum 25.00 Minimum = 2.00

As shown in Table 8, a significant difference was found for 'care' only ($p<.05$, two-tailed). The significant difference was between parents of eating disordered and of depressed girls (Mann Whitney: U= 4, $p<.005$ **, two-tailed), indicating that parents of girls with eating disorders reported significantly less care in their own childhoods than those from either depressed group families.

Current attachments

Mean parental ARAQ scores for the four patterns of attachment ('angry withdrawal', 'compulsive care-giving', 'compulsive care-seeking' and 'compulsive self-reliance') are shown in Appendix 20. There was no significant difference between scores between the three parental groups on a Kruskal Wallis test. Unlike with the adolescents, descriptively there was relative uniformity in distribution of highest parental scores, with 79 % of parents across all three groups, scoring highest for 'compulsive care-giving', 17.5 % for 'compulsive self-reliant', only 3.5% for 'angry withdrawal' and none for 'compulsive care-seeking'. As with adolescent data on this measure, care must be taken not to over-emphasise these non-significant findings.

4C: Intergenerational correlation on administered measures

On the PBI, a significant correlation on the 'overprotection' scale between adolescents and at least one of their parents was achieved using the non-parametric Spearman Rank Correlation Coefficient (N = 20, rs = 0.486, significant at p<.05*). There was not a significant correlation on the 'care' scale (N = 20, rs = .025, p =.918). On the ARAQ, the only significant correlation that occurred between adolescents and parents was on 'compulsive care-seeking' (N = 18, rs = .696, p=.037, significant at p<.05 *, two-tailed). On the BDI II and self-report symptom forms there was no significant correlation between adolescent and parent symptom scores (N = 18, rs = .217, p = .386 and rs = .063, p= .804 respectively).

3.1.5. Hypothesis 5: Attachment style and clinical diagnosis

Ratings given to the three groups of interviewees on the Reflective Functioning Scale (Fonagy et al, 1997) are shown in Table 7 (below). There were significant differences between the three sets of ratings using Kruskal Wallis (Chi Square = 10.95, Median = 3, Range = 6, Maximum = 7, Minimum = 1, p = .004**, two-tailed). Subsequent Mann Whitney tests revealed these differences to be significant between Eating Disordered and Control groups (U = .000, p=.006**, two-tailed) and between Depressed and Control groups (U=.000, p=.005** two-tailed). The Eating Disordered group showed the lowest RF (the most 'deactivated') followed by the 'depressed' group, who showed more 'preoccupied' or 'hyperactive' RF. These codings were confirmed with an independent rater, achieving a percentage of agreement of at least 83 % (Kappa = 0.83). Caution needs to be observed in generalising from these findings, however, due to the small sample size.

Table 9 – Reflective Functioning scores across the three groups of interviewees (N = 15)

Participant no.	Eating Disordered Group	Depressed group	Control Group
1	RF 1A – Disavowal • (comorbid)	RF 3B – Over-analytical/hyperactive	RF 5 – Ordinary
2	RF 3 (A) – Naïve –simplistic	RF 3(B) Over-analytical/hyperactive	RF 7 –Exceptional
3	RF 1A – Disavowal (comorbid)	RF 1(A) – Disavowal	RF 5 – Ordinary
4	RF 3 (A) – Naïve-simplistic	RF 3(B) – Over-analytical/hyperactive	RF 5 – Ordinary
5	RF 1A – Disavowal (comorbid)	RF – 3 (A) – Naïve-simplistic	RF 5 – Ordinary
MEANS	**1.8 (1.10)**	**2.6 (.89)**	**5.4 (.89)**

- only this interview rating was not supported by inter-rater reliability

3.1.6. Hypothesis 6 : Clinical adolescents and maltreatment/neglect/parental frightening behaviour

Within interview transcripts, independent raters agreed that eight transcripts described incidents classified as emotional abuse, three physical abuse, two sexual abuse, six neglect and seven frightening parental behaviour. All abuse ratings and six of the frightening behaviour ratings came from the depressed group and eating disordered depressed sub-group. Seven adolescents scored on more than one dimension (the three co-morbid and four of the depressed group). Additionally from clinicians/casenotes, there were a further five known incidents of maltreatment (two of sexual abuse and three of physical abuse). The most severe of these came from within the eating disordered group (suicidally depressed participant), the rest from the depressed group.

3.2 Qualitative Results

3.2.1. Overview

The qualitative research questions (see 'Introduction' page 14) explored the way adolescents across the three groups perceived their attachments and the themes they generated in talking about early experiences with caregivers. All girls interviewed responded well and answered questions without undue difficulty. Transcripts were examined using a qualitative approach based on Interpretative Phenomenological Analysis (IPA) (e.g. Smith 1994, 1995) and sub-ordinate and superordinate themes were generated as outlined in 'Methods'. It is acknowledged that this was not a full IPA analysis due to the constraints of a mixed methodology. Themes fell under the following superordinate clusters, some of which interestingly corresponded with particular quantitative measures (specified in brackets), supporting the choice to assess these features of adolescent attachment experience:

- *Quality of family attachment relationships/family functioning (PBI; ARAQ; FACES II)*
- *Attachment style (PBI, ARAQ)*
- *Relationships with peers/others (ARAQ for some)*
- *Reflective capacity (Reflective Functioning Scale)*
- *Separation/Individuation (Separation-Individuation Test of Adolescence)*

- *Own and family symptomatology (all symptom measures)*
- *Emotional Experiences (all symptom measures)*
- *Personality characteristics*
- *Key life events*
- *Developmental issues: sexual, intellectual, social.*

Themes were placed in order of importance within each cluster, according to the numbers of participants to whom themes applied and the quality and quantity of instances of themes within each transcript (Appendix 21). An overall concordance level of 89% (Kappa = 0.89) was agreed with the inter-rater in terms of themes generated, using the detailed comparison (two transcripts) and 5-point scale (four transcripts) (Appendix 19).

This section reports the accounts given by the fifteen adolescents of their attachment experiences. It is stressed that these accounts are these adolescents' *perceptions* of their relationships and not a measure of objective reality. Quotations give a flavour of themes generated, although it is naturally impossible to summarise into brief quotations themes which pervaded whole transcripts. A more comprehensive flavour of interviews is given in the worked transcript samples in Appendix 22 and exposition of second-order themes in Appendix 23, although again these necessarily summarise. It is acknowledged that labels generated by the researcher to act as necessary short-hand descriptors for themes are subjective and could have been conceptualised differently. Throughout this section, pseudonyms and/or quotes from participants are followed by the group to which they belonged (E = Eating Disordered, D = Depressed, C = Control).

3.2.2 Common themes across the three groups

A table of common themes between and within the three groups is depicted in Appendix 21. The data showed a comparative lack of common themes across groups, emphasising instead between-group differences, particularly between control and clinical groups. The only truly universal theme was of the (implicit or explicit) transmission of own attachment experience onto proposed future parenting style in response to question 21 (see Appendix 10). All participants showed in their responses that they intended to behave towards their child as their

parents had towards them, even when, as with some clinical participants, they expressed a conscious wish to do the opposite. The fact that this theme was important in interview transcripts contrasts with its comparative absence in self-report questionnaires. Other themes that overlapped all three groups, although not present in all interviews, related to common adolescent developmental milestones, including school/peer issues (academic pressures, friendships, bullying), sexual development and relationships. Although these themes were common to all groups, the way in which they were talked about differed, with the control group depicting better sibling, peer and romantic/sexual relationships than the two clinical groups and fewer instances of academic difficulties and bullying.

3.2.3 Differences between clinical and control groups

Despite the few themes common to all three groups, most participants in the control group reported similarly difficult or distressing life events or problems to those in the clinical groups. Thus Clare's (C) parents had divorced and both re-married and Imogen (C) talked of her fear as a young child when her father had smacked her. These girls seemed, however, to have been able to assimilate difficult experiences and not be unduly affected by them. The way in which controls talked about their attachment relationships also differed notably from the clinical groups, in that it was more integrated and incorporated good and bad experiences in an thoughtful, reflective way, as shown in the example below:

" I didn't really see him (father) **and sometimes we'd be lying in bed and...he'd come and kiss goodnight..I remember I used to turn over and think: "You weren't here! I don't want your kisses!"...It made it a nice novelty when he was around, but I think I resented him a bit too"** (C)

Also significant was the perceived presence of a secure, close and loving relationship with at least one parent (usually mother) in early childhood. This seems to have been highly protective for control group participants when faced with later stressors and difficulties:

"I've always been really close to Mum and...known that I could go to her about anything" (C)

Control group narratives portrayed a greater ease with separations, development of autonomy and increased self-confidence/self-esteem compared to the two clinical groups. Laura (C), for example, talked of how she had increasingly managed to separate from her parents in adolescence and now felt closer to her friends, while Imogen talked of feeling content within herself:

"I find it easy to make friends...I'm fairly confident...I'm happy to admit what my good points are and what my failings are" (C).

3.2.4 How do adolescents with eating disorders and clinical depression talk about their attachment experiences?

- **Common themes between the two groups**

All adolescents within the two clinical groups described impoverished early attachment relationships, whether these were characterised more by separation anxiety/enmeshment, as in the eating disordered group, or rejection/abuse/neglect as in the depressed group. Jenny (E), gave repeated examples of enmeshed family relationships and described, at 17, being totally unable to cope if her mother went away for even a day, whilst Nadia (D) described a father who had sexually abused her and a mother who had been unable to provide protection, due to her own mental health problems. The roots of this insecurity seemed to lie for nearly all of the clinical interviewees in a parental lack of emotional containment*, whether or not these relationships were also abusive:

"She's (mother) **a weak person...I used to take out all my anger on her...just pick fights and stuff and she just used to take it"** (D)

All reported an attachment style characterised by compulsive care-giving/care-seeking behaviours and/or compulsive self-reliance. There were more instances of the former behaviours reported among depressed adolescents and of the latter among those with eating disorders, although there were overlaps. Thus Judy (D) and Jane (E) both reported being their mothers' confidantes (care-giving) and Lucy (E) and Louise (E) claimed extreme independence and self-reliance.

Also common to both clinical groups were reported painful life events, with which the adolescent seemed to have felt unable to cope, perhaps due to their lack of early security. Thus bereavements, trauma, parental conflict, bullying and problems with peers were all features of these accounts, but what distinguished these adolescents from controls who had also experienced difficulties, was the sense of overwhelming devastation upon their self-esteem and mental health as a result:

" When Granddad died (bursts into tears) **it was just awful.... It was so awful for my Mum. I felt so sorry for her."** (E)

The early lack of containment could perhaps be explained partly by the fact that nearly all clinical participants recounted experience of at least one parent with significant mental health problems. Of the ten clinical interviewees, six reported mothers with notable mental health disturbance (mostly depression) and five reported this experience with fathers/other close family members. Such difficulties seemed frequently connected by the adolescents to a poor marital relationship and impoverished family functioning. Three interviewees also had parents who were abusing substances.

There were also issues with sexuality and sexual development across the two clinical groups. Most clinical adolescents described problems during puberty, in romantic/sexual relationships and with sexual boundaries within the family:

"I developed really early...and I've always been bigger than most of my friends, which has been hard... my Dad...used to be really insensitive..used to barge into my room" (E)

Finally, most of the clinical participants depicted disrupted early childhoods, including many parental job changes, house moves, early separations from parents, periods of time living abroad, frequent changes of school and/or family financial or social problems. This was in contrast to the control group who described a comparatively stable upbringing.

- **<u>Distinct issues: Eating Disorders</u>**

There were some themes common and exclusive to eating disordered interviewees. Most

portrayed experiences of prolonged actual separations from caregivers during early childhood, to a greater extent than control or depressed interviewees. Two described living apart from their parents for more than six months before the age of five and one having been brought up by grandparents.

Food, eating, body image and weight unsurprisingly emerged as significant themes. Most eating disordered adolescents also reported early difficulties with food and/or an experience of serious physical illness as a younger child.

There seemed, however to also be a within-group difference in these transcripts. For the two girls who were not also severely depressed, predominant themes were around enmeshment with mothers, more distant/hostile relationships with fathers and past and current separation anxieties. These accounts were filled with over-generalisations, purported lack of memories and minimising of painful experiences. Both girls denied they had a significant eating problem. Families were described with a degree of idealisation that felt unreal and, in fact, conflicted with evidence provided elsewhere of caregivers (particularly fathers) being at times extremely intrusive and overbearing:

"Dad is totally insensitive...he just doesn't even think about other people" (E)

These two accounts also came across as presentations of much younger children. At seventeen, Jenny, for example described her Christmas routine with the emotionality and language of a small girl. Families of these two girls were portrayed as competitive and ambitious. They were depicted as extremely sporty, busy and (almost manically) active. Both girls went to highly academic schools and felt under pressure to be successful, particularly from their fathers. This theme did not emerge at all in the depressed group and to a lesser extent among eating disordered interviewees who were also severely depressed:

" If I'm doing a class or jumping on the horse, it's never good enough for him (father) **for me just to win one..I have to win the next one as well. He's really ambitious for me. He always wants me to be the best."** (E)

The second (severely depressed) sub-group of interviewees showed more haphazard narratives.

All three transcripts combined aspects of self-reliance, enmeshment, care-giving and care-seeking behaviours. Unlike the less severe group, there seemed to be no one unifying attachment preoccupation.

These accounts were all extreme. The three girls reported evidence of abuse, neglect and frightening parental behaviour (e.g. threats, silent treatment) mingled with intense enmeshment with at least one main caregiver, almost as if the worst pathologies of the eating disordered and depressed groups had somehow been directly fused. Lucy, for instance, reported neglect, emotional and physical abuse from parents, father-enmeshment and both care-giving and compulsive self-reliance. Intense anger was also a feature of this sub-group alone and was particularly evident in Louise's transcript.

Disavowal strategies and impoverished reflective-function* seemed clearly present, as with the first sub-group, but with this sub-group they were combined with moments of apparent insight and thoughtfulness which would then be quickly lost again, to the confusion and disorientation of the listener. Some girls even expressed conflicting evidence within the same sentence:

"**I find him** (brother) **very hard to deal with.... he's completely opposite to me...I can't deal with him. We have arguments, but what brother and sister don't.... yeah, I'd say the relationship is very good and when we're older I think it will be very very good and I'd like to think he feels the same way** " (E).

- **<u>Distinct Issues: Depression</u>**

The overwhelming feeling given by the interviews with the depressed girls was one of intense preoccupation with their (in all cases) concerning histories. In two cases the researcher experienced difficulties terminating the interview. Three girls cried at various points during their interviews and imparted to the researcher in their presentation a sense of hopelessness and despair. Two girls conveyed such a powerful sense of suppressed anger that the researcher felt quite overwhelmed by them.

The most notable feature of the depressed group was that all spoke at length about neglect and rejection by at least one parent in early childhood. Often such perceived parental absence or

neglect was accompanied by reported separation anxiety, anger and extreme distress at the time, which had never fully abated:

"I stopped seeing my Dad when I was three and he's never been in contact since. He's never sent a card, a letter, a phone call... nothing.....that just says to me that he don't care " (D)

All depressed participants revealed significant themes of physical, sexual and/or emotional abuse in early childhood. In all but one case a parent had apparently perpetrated this. In one case the older brother was the reported perpetrator of physical and emotional abuse. Two girls described multiple abuses. Admittedly, small numbers make generalising from these findings impossible, although the trend is interesting, especially as it was less prevalent as a theme among the eating disordered girls interviewed who were not also depressed.

Like the comorbid eating disordered group, but unlike eating disordered girls without severe depression, anger and hostility to a parent/caregiver was evident explicitly or implicitly in these accounts.

"My Dad...doesn't appeal to me as a person..If he wasn't my Dad, I wouldn't choose to know him" (D).

Often this anger was also turned inward as considerable self-directed hostility and impoverished self-esteem:

"I suppose they (parents) **weren't ...horrible..it was because I was unreasonable..that's my own fault."** (D).

More optimistically, most depressed girls did (unlike the comorbid eating disordered group) elicit the theme of protective relationships with significant others. Charlotte (D), for instance, described supportive relationships within her extended family and Nadia (D) a close relationship with her Aunt.

CHAPTER 4: DISCUSSION

4.1 Results summary

Quantitative results indicated that adolescents with eating disorders (anorexia and bulimia nervosa) and/or clinical depression presented more severe clinical symptomatology than a comparison control sample. This supports previous research findings (e.g. Scott Brown, 1999). Adolescents referred with depression also exhibited more pathological levels of family functioning (cohesion and adaptability) and maternal bonding (care and overprotection). Clinical groups exhibited some differences from controls in aspects of separation-individuation (rejection expectancy and nurturance / enmeshment for depressed and eating disordered girls respectively). Parents of adolescents with eating disorders or depression did not show significantly higher levels of symptomatology than control group parents. Reflective Functioning (RF)* analysis of attachment interviews revealed that clinical adolescents displayed impoverished reflective capacity compared with controls. There were also significant differences between the two clinical groups: eating disordered adolescents displayed lower levels of RF. There were significant within-group differences in scores within the eating disordered group on certain measures (FACES II, SEDS and YSR) and a significant trend on another (PBI) with those with comorbid depression scoring more severely than those without. There were similar differences reflected in RF scores. There were no comparable differences within the depressed group.

Qualitative analysis revealed a notable lack of common themes between the three groups, with the only universal theme being the (purported) intergenerational transmission of parenting style. Other common overall themes related to general developmental issues and significant life events. More themes were held common to the two clinical groups, including perceived insecure early attachments to parents and resultant lack of individuation and security. Also common was a more insecure attachment style of compulsive self-reliance, compulsive care-giving or compulsive care-seeking. Distinct to the eating disordered group were themes of disavowed reflective functioning, early feeding difficulties, serious illnesses, competitive,

ambitious and sporty families and family enmeshment. Unique to depressed adolescents were expressed occurrences of familial abuse or neglect, intense anger and distress, preoccupation with attachment relationships (hyperactivation) and with negative life events.

There was also a division in themes generated within eating disordered interviews, with comorbid girls presenting as more extreme and 'disorganised'.

4.2 Critical evaluation of the study

4.2.1. Methodological Issues

Before examining the implications of these results, it is important to address various methodological issueswith the project's design and implementation.

- **Measures Administered**

Despite their robustness, there were problems with some measures chosen and their administration. The PBI was only administered once to each participant due to the number of other questionnaires used. More accurate results may have been obtained had the measure been administered to each participant twice, once for bonding to mother and once for bonding to father (Biggam and Power 1998). Nonetheless, the results obtained on this measure for the adolescent group were statistically significant and the selection of mother fits Bowlby's theory of 'monotropism'* (Bowlby 1969; 1980).

It was also an omission that most administered measures examined attachment to parents only. Administering a wider measure, such as the IPPA (Armsden and Greenberg, 1987) may have redressed this imbalance. This measure has uncertain reliability and validity, however, as discussed above ('Introduction', page 4).

Administering three separate measures of symptomatology to adolescents (BDI II, SEDS and YSR) and two to parents (BDI II and YASR) may have been excessive. The questionnaires served a dual purpose, however, as screening tools and measures of symptomatology. Indeed, the robustness of the Achenbach measures may have contributed to their having yielded more severe symptom scores than the BDI II or SEDS. They also elicited additional symptoms.

The decision to utilise the BDI II with adolescents is perhaps controversial as the norms are obtained from adults. Many adolescents reported that they did not like the measure because of its negativity. This may have influenced their responses. The BDI II was chosen, however, due to its robust reliability and validity. There is also a lack of suitable alternative depression measures for adolescents, as discussed above.

The Reflective Functioning Scale (Fonagy et al, 1997) is complex and not easily applied. The nine categories are not always distinct. The scale also assumes developmental linearity. Neither researcher nor inter-rater had undertaken formal training in use of the RFS which casts doubts as to the validity and reliability of codings. Future replicatory studies should endeavour to improve this aspect of design. Use of the scale nonetheless produced some interesting findings in terms of hyperactivating/deactivating strategies within clinical groups.

- **Self-report measures**

Statistically non-significant results were obtained on some self-report measures, even when participants were known to be symptomatic. This indicates potential flaws in relying upon self-report data with such clinical populations, perhaps due to unconscious rules governing internal working models (Cooper, Shaver and Collins 1998). Those with insecure attachment styles may also answer defensively to avoid painful affect (Vandereycken, 1994) and/or be susceptible to demand characteristics (Kenny, Lomax and Braback, 1998). Self-reported attachment insecurity may also be a consequence, rather than a cause, of psychopathology (Burbach et al., 1989).

The problem remains the lack of suitable alternative measures of attachment for adolescents. The use of the attachment interview aimed to go some way to compensate. The AAI, upon which the current interview was based, is thought to "surprise the unconscious" (Ward et al., 2000, p. 48) and may provide a truer picture of attachment experience. The only completely accurate way to control for self-report bias, however, is to incorporate observational and behavioural data (Rutter, 1995) and/or therapist/other ratings. This was beyond the scope of this project.

Adaptation of the Adult Attachment Interview Protocol

The decision to utilise an interview transcript so closely modelled on the AAI (George et al., 1985) was also controversial. This interview, whilst extremely robust (O'Kearney, 1996; Ward et al., 2000) is very probing and usually only administered by trained experts. The AAI protocol also assumes that security of attachment is related to coherence. Although there is unequivocal evidence for this, recent theories of meta-monitoring* have shown that adolescents' discourse of their experiences is correlated to attachment style (Kobak and Cole, 1994). The AAI has also been developed for use with adults only and has only been used sparingly with adolescents (e.g. Kobak and Sceery, 1988; Kobak and Duehmler, 1994).

Despite drawbacks, the decision to adapt the AAI for this study is upheld: besides the demonstrated reliability and validity of the protocol (Fonagy et al., 1996), AAI questions tapped the broad scope of adolescents' actual attachment experiences in a way that other protocols (e.g. the 'ASAI', Richard et al., 1998) do not (Fonagy, Redfern and Charman, 1997). All adolescent interviewees engaged well in the interview process. Nonetheless, important ethical issues are raised using the AAI and it was therefore important to have a thorough debrief procedure (Appendix 18).

- **Qualitative Analysis**

The qualitative analysis assigned thematic concepts that were researcher-generated and elicited themes based on abstract concepts (e.g. 'Reflective Functioning') alongside more concrete ones (e.g. reported experiences of maltreatment). Perhaps also problematically, IPA analysis aimed to encompass both themes that were important quantitatively (occurring several times within a transcript) and qualitatively (e.g. the overwhelming 'feel' of an interview). The keeping of a Research Diary would have been a valuable addition to the qualitative analytic process.

- **Other methodological / ethical concerns**

The use of mixed methodology itself can be seen as problematic: The study was perhaps over-

ambitious in scope.

There was no direct mapping between quantitative and qualitative data and even within the quantitative paradigm, there was an absence of clear score correlations between different measures. No attempt was made, however, to provide an all-encompassing attachment 'score' for each participant. Interest lay in assessing a broad range of attachment relationships. Mixed methodology also added depth and thoroughness.

There were also more general methodological constraints, created by the limited time-scale. Small sample sizes made generalisations difficult. For the quantitative sample, at least sixty adolescents would have been needed to ensure more powerful results (Clark Carter, 1997). This was not possible due to time limitations and difficulties recruiting clinical participants (due to clinician reluctance and potential participants declining to take part). With qualitative analysis, however, the philosophical basis is different and the emphasis upon theoretical rather than randomised sampling. Statistical power is therefore less relevant. The small number of interviews conducted does, however, question the generalisability of findings pertaining to experiences of maltreatment and assignations of reflective functioning.

Questionnaires were sent postally. This could have affected the accuracy of questionnaire data. Although participants were encouraged to complete the measures at one sitting, in a quiet room with no distractions (Appendix 16), there was no possibility of controlling for this. There may have been the additional fear about completed questionnaires being discovered, which may have made adolescents less honest in their responses.

There were problematic aspects of comparing symptom scores between clinical and control groups, as the control group was not naturally occurring but selected, with potential controls scoring within the clinical range being excluded. This may have influenced the significant results achieved. Nonetheless, this does not change the fact that the two clinical groups were more severe than a non-symptomatic population (even if orchestrated) and does not affect differences found between the two clinical groups.

There were problems implicit in the recruitment of 'controls', some being excluded due to

disclosure of mental health problems. Methodologically, this problem was overcome because there was a high enough response rate from schools to exclude potential controls presenting clinically. It was ethically concerning that more excluded controls did not give the researcher permission to contact their G. P.

Recruitment of parents, easy for controls, was more difficult for clinical adolescents, many of whom did not wish their parents to be involved. Perhaps it is encouraging that so many parents were recruited despite this. Only eight out of twenty clinical participants had no parental data. There were only four non-white participants and only one agreed to be interviewed. There was, however, a good mix of participants from different socio-economic categories and of different ages. Important for future research would be to recruit a more ethnically diverse sample.

Adolescents with anorexia and bulimia were combined for ease of recruitment into one group. This is not ideal, as major clinical differences exist between these disorders (Williams, 1997; Ward et al., 2000). It seems important to use more homogeneous samples in future studies. A further significant confound was in the high levels of depression in four of the eating disordered participants. As explained earlier, however, to exclude dual diagnosis would have difficult methodologically and distorted clinical reality (Ward et al., 2000). The differentiation within the eating disordered group also produced interesting results.

A critical stance must be taken on using one linear model, like Attachment Theory, in understanding psychopathology (O'Kearney, 1996). The present study did not focus adequately on other predisposing factors in eating disorders and depression in adolescence such as genetic, biological and social factors. Of course, to be this inclusive was not possible, nor desirable, for the aim was to isolate attachment perceptions. That attachment disturbance remains only one way of conceptualising adolescent psychopathology must, nonetheless, be remembered (Rutter 1995).

Finally, it remains unclear how much the attachment factors discovered relate purely to adolescent eating disordered and depressive symptomatology. Could similar attachment patterns be found in adolescents with conduct disorders or psychosis? There is a need for

further studies to investigate what is distinct about these particular clinical populations and what are phenomena more widely characteristic of adolescent psychopathology.

4.3 Discussion of Results

Methodological concerns acknowledged, some significant and interesting findings were generated, with implication for future research and clinical intervention.

4.3.1 General findings

- **Maternal bonding, family functioning and adolescent psychopathology**

The study examined maternal bonding and family functioning between groups. Depressed adolescents showed more significant ratings for low maternal care, rejection expectancy and pathological family functioning and eating disordered adolescents for overprotection and nurturance/enmeshment than did controls. In interview, depressed adolescents (with or without eating disorders) described parents who were emotionally uncontaining and preoccupied and often directly neglectful or abusive. Eating disordered interviewees without significant depression presented a more naïve picture of family life, with considerable enmeshment.

These results cautiously substantiate much theoretical and research literature pertaining to attachment within eating disordered and depressed individuals (Parker 1983 a, b; Ward et al., 2000). They support previous findings of lower care and family pathology reported by depressed patients (Parker 1982, 1983a; Cubis et al., 1989) and previous conclusions that eating disordered patients present a more idealised view of family life, akin to controls (Russell, Kopec-Schrader, Rey and Beaumont, 1992).

The results provide tentative substantiation both for analytic theories of impoverished early relationships with caregivers, for instance the potential importance of enmeshment or parental over-control in the aetiology of eating disorders (Bruch 1974; 1978; Chernin, 1985; Lavik et al., 1991). They also lend support to systemic theories citing conflict, dysfunction and rigidity in families of clinically depressed adolescents (Richter, 1994). This finding was not replicated

for eating disorders, perhaps due to problems of relying upon self-report data with this more 'deactivating' population (Kobak et al, 1993). 'Affectionless control' was not significant in the eating disordered sample as some previous studies have found (Calam et al., 1990; Rhodes and Kroger, 1992) perhaps for the same reason, or due to the combination within the same group of eating disordered girls with and without significant depression. It seems that the present findings support previous theoretical and research evidence of poor care and pathological family functioning for depressed girls. Eating disordered girls who were not also significantly depressed seemed rather more overprotected and enmeshed with caregivers than neglected or uncared for.

- **Abuse, neglect and frightening parental behaviour in adolescent depressive psychopathology**

Despite the small numbers of interviewees, which makes generalisation difficult and speculative, it is nonetheless interesting that among all depressed adolescents interviewed (including comorbid individuals) three raters agreed that all had described some form of early familial abuse or frightening behaviour. In all but one case this had reportedly come from a parent.

Such a picture fits the theoretical basis in Attachment Theory of the potential role of childhood maltreatment in the formation of insecure attachments and psychopathology (Bowlby, 1969, 1982, 1988). The findings here also provide tentative support for previous studies citing correlations between maltreatment and adolescent disturbance (e.g. Candelori and Ciocca, 1998). Depressed adolescents could be hypothesised to be showing in interview evidence of an 'Internal Working Model' (Bowlby 1969) or 'template' (Crittenden, 1991) of 'abused-abuser' or 'abandoned-abandoning' which they re-enacted in their adolescent relationships with serious consequences for their social functioning and mental health.

It is perhaps notable that the most symptomatic girls all had known (from clinicians/casenotes) and/or reported histories of abuse or significant neglect by a main caregiver and most exhibited also a range of comorbid symptoms. For example, Louise (E), physically and sexually abused by her father while her mother was hospitalised for depression, had a history of self-harm and

suicide attempts and was felt by her clinician to meet criteria for Borderline Personality Disorder (BPD).

It is perhaps surprising, in light of their painful early experiences, that the non-comorbid depressed girls were not more symptomatic. Although it is difficult to assign a label to a range of reported relationships, most depressed girls seemed more pre-occupied/ambivalent (hyperactivating) rather than either avoidant or 'disorganised', the most pathological attachment type (Main and Solomon, 1990, van IJzendoorn, 2000). A possible, although speculative, explanation was that depressed group girls all reported experiencing the presence of at least one protective alternative attachment figure, who may have been able to provide some additional security to prevent more entrenched psychopathology developing (Tyszkowa, 1991; Dunn and Kendrick, 1982): Perhaps the most symptomatic girls had lacked protective relationships and thus were at greater risk. This certainly seemed true of Louise and Lucy who had turned to extreme self-reliance. The hypothetical link between symptom severity and absence of alternative protective attachments requires substantial further investigation.

- **Intergenerational attachment transmission**

Self-report questionnaires did not yield significant correlations between adolescent and parent scores. In fact, parents of depressed girls actually reported higher levels of care and lower levels of overprotection from their own mothers than did controls (Hypothesis 4B, page 36). This finding seems most likely to be attributable to methodological flaws, given the substantive literature on intergenerational transmission of attachment (Fraiberg et al., 1975; Fonagy et al., 1991).

Nonetheless, the fact that there was this trend among depressed group parents and also a notable discrepancy on this theme between adolescent questionnaire and interview data, indicates another possible, if tentative, explanation. It is interesting that among the ten clinical interviewees, seven reported significant mental health problems of a parent whereas in the questionnaire data of these same parents, only three reported clinically significant scores on the YASR, none in the depressed group. Main and Goldwyn (1984) showed that mothers at risk of rejecting their infants were those who exhibited distorted, often idealised,

representations of their own (frequently negative) attachment experiences. Thus, if intergenerational transmission of insecure attachment is unconscious, then it would not be elucidated in self-reports (Crittenden, 1997 a, b). Admittedly, such a hypothesis is highly speculative, but interesting and merits further investigation, perhaps through direct comparison of parental self-report data with AAI transcripts.

- **Psychopathology and meta-monitoring**

As predicted by "Control Theory" (Kobak and Cole, 1994; Cole-Dekte and Kobak, 1996) attachment style within eating disordered and depressive adolescents (shown in reflective functioning scores) was qualitatively different, with eating disordered adolescents presenting as more 'deactivated' (avoidant) and depressed adolescents more preoccupied ('hyperactivated').

The results of this analysis thus lend tentative support to "Control Theory" and further weight to Bowlby's theories of internal working models of attachment (e.g. 1980). They also further support Crittenden's 'dynamic maturational' theory (Crittenden, 1997 a, b) of dissociative cognitive functioning in adolescents who have suffered early traumas. Furthermore, these results also cautiously substantiate some of the psychoanalytic eating disorder literature hypothesising that adolescents may fail to report psychopathologies due to highly avoidant coping styles and may require their eating disorder symptoms to signal their distress (Williams, 1997, 1998).

4.3.2 Theory Building: Comorbidity, symptom severity and disorganised attachment in adolescence - a proposed model

Despite highlighting significant correlations between depressed adolescents and reported pathological maternal bonding and poor family functioning, the results obtained did not produce findings as significant as predicted in terms of insecure attachment and adolescent psychopathology. The methodological difficulties outlined above may provide explanation. There is however, a more theoretical explanation, explored below, based on between and within-group differences. Such an explanation, if highly tentative, nevertheless yields interesting questions about the potential importance of cognitive distortion (dissociation) and

'disorganised' attachment within adolescent disturbance.

4.3.2.1 Eating Disorders, comorbidity and disorganisation

Within the eating disordered sample, there appeared to be two very different sub-groups of girls: those with significant comorbid depression (moderate or severe BDI II scores) and those without. This within-group differentiation was interestingly not mirrored within the depressed sample, other than finding that girls with more severe depression exhibited greater overall psychopathology, which is not surprising.

- **Sub-group 1: Eating disorders without comorbid depression: a profile**

Compared to the comorbid group, the first group of eating disordered girls (participants 2, 3, 4, 6, 9 and 10) scored more highly for "Affectionate constraint" and even "Optimal" bonding types on the PBI, showed higher levels of "Healthy Separation" and "Nurturance/Caretaker Enmeshment" and lower levels of "Rejection Expectancy" on the SITA and reported significantly lower levels of symptomatology on the SEDS and YSR. Their family functioning scores were significantly better than those of their depressed and eating disordered counterparts and not significantly worse than controls. In their interviews (participants 2 and 6), there was an emphasis on closeness and 'normality'. In fact, on the surface, there seemed little to distinguish these girls from controls, aside from their exhibition of significant eating pathology.

From both PBI and SITA data and qualitative interviews there seemed, however, to be a link in this group between eating disordered symptomatology and the presence of enmeshed family dynamics. This supports findings within other research studies which have characterised the 'loose' demarcation between self and others present in eating disordered individuals, whereby personal identity is organised around a strong need for approval from significant others, together with a fear of rejection by them (Friedberg and Lyddon, 1996). These findings also tentatively support Chernin's (1985) hypothesis of the entangled and competitive relationships within some eating disordered families, particularly between mothers and daughters.

'Sub-group 1' eating disordered adolescents also showed apparent use of 'deactivation'

(Kobak and Cole, 1994) as an internal working model * (Bowlby 1969) to manage difficult attachment experiences, portraying these relationships extremely idealistically, rather than as what they were: caring certainly, but also intrusive and enmeshed. The deactivation possibly meant that these aspects of the relationships, too painful to be borne, were (hypothetically) split-off into eating pathology, which perhaps mirrored the adolescent's struggle both to remain close to the parent(s) and to erect a "no entry" system of defences (Williams, 1997).

- **Sub-group 2: Eating disorders and comorbid depression: an indicator of attachment disorganisation?**

Eating disordered girls in the second group (participants 1, 5, 7 and 8) showed a more confusing profile. Three scored for "Affectionless control" on the PBI, one for "Affectionate Constraint". One was predominantly compulsive self-reliant on the ARAQ, one compulsive care-giving, one angry withdrawn and one said she had no attachment figure. On the SITA and FACES II there was a similarly contradictory pattern. Symptom scores and family functioning were significantly worse than for the non-comorbid group. Interview narratives hinted strongly at early experiences of neglect or abuse, although, with the exception of Louise, such incidents were not directly reported. In two cases, they were known about from other sources.

Whereas with 'sub-group 1' eating disordered adolescents, there was seemingly a cognitive strategy of deactivation, with 'sub-group 2' there was a more uncomfortable mix of deactivation and hyperactivation. The failure of some to report seemingly important aspects of early traumatic history indicated extreme deactivation whilst their degree of demonstrable distress and depth of narrative indicated greater preoccupation. Unlike the first eating disordered sub-group, therefore, with these girls what seemed to differentiate them from the depressed group, was not so much early attachment experience as current attachment style.

4.3.2.2. A Conclusion: Maltreatment, disorganised attachment and severe adolescent psychopathology

Thus if the eating disordered girls without comorbid depression seemed more 'deactivated' (or 'avoidant') and the depressed girls without eating disorders appeared more 'hyperactivated' ('preoccupied'), the girls with comorbid depression and eating pathology could be said to be

more unresolved or 'disorganised' (Main and Solomon, 1990; Bowlby, 1977).

'Disorganisation' as an attachment category has rarely been studied in adolescence. In adolescent attachment interviews, however, one would expect from adult research (Main et al, 1985) that 'disorganisation' would be characterised by parallel cognitive patterns of contradictions in narrative: recall combined with purported memory lack; over-generalisation combined with specification. These were the very characteristics of interviews of girls in the present study evidencing more than one pathology (eating disorders *and* depression). This supports (albeit extremely tentatively given very small numbers) previous research findings that 'disorganised' attachment exists predominantly where there is a compound of clinical problems (van IJzendoorn, 2000).

It could thus be hypothesised that there could be a particular group of insecurely attached young female children who may be vulnerable to developing severe, comorbid symptoms in adolescence: those showing 'disorganised' attachment status in early life (Ainsworth et al, 1978; Fonagy et al., 1991). Could early disorganised attachment therefore be a precursor of severe adolescent pathologies, such as adolescent-onset BPD* (Steiner, 1979; Upson, 1998)? The latter diagnosis is indeed characterised by such multiple pathologies (suicidality, eating disorders, self-harm, depression and intense anger, DSM IV, 1994). Indeed, BPD has been described as the "I hate you - don't leave me" scenario (Kreisman and Strauss, 1989) which would seem to be the epitome of disorganised attachment status: approach combined with avoidance (Ryle, 1997; Moskovitz, 1996).

Attachment disorganisation, like BPD, has been shown to be highly associated with experiences of significant early maltreatment and/or 'frightening behaviour' (Schuengel et al., 1999). A combination of this with an absence (or perceived absence) of alternative protective relationships could cause the child to resort to self-reliant internal defences for survival, via cognitive dissociation (Crittenden, 1997 a, b). If such internal cognitive models are indeed enduring (Bowlby, 1969) then what at the time may be an adaptive strategy to aid the infant/young child maintain proximity to an abusive or rejecting caregiver could become entrenched and have a pathological affect in adolescence when the individual attempts to

undergo "second individuation" (Blos, 1962).

4.4 . Clinical implications

4.4.1 Early intervention and prevention

The present study supports a range of previous work that argues that attachment disturbance in infancy and early childhood may be a significant risk factor in adolescent psychopathology. It therefore seemingly substantiates clinical programmes that intervene early with parents and infants to foster more adaptive attachment relationships before internal working models become too established (Cicchetti & Toth, 1995).

'At risk' families may be identified by observation and/or by targeting parents with disrupted attachment histories (Vandereycken, 1994), significant mental health problems (Woodside and Sheckter-Wolfson, 1990), or experiences of abusive relationships. Important areas for clinical work could be working with parents with such histories when their children are infants, to help them "rework" cognitive-affective internal models (Bowlby 1973; 1980; Main et al., 1985). This may be especially important with 'disorganised' parents, whose children may be at greatest risk of later psychopathology (Main and Goldwyn, 1984; Fraiberg et al., 1975).

Van IJzendoorn and colleagues have undertaken extensive research into the efficacy of early attachment-based interventions (e.g. Bakermans-Kranenburg, 2000). They suggest preventative work could involve both behavioural programmes and parental psychotherapy. So far, outcome studies have favoured parent-child behavioural interventions (Bakermans-Kranenburg, 2000) although this could be because longer-term follow-up studies have yet to be carried out. Intuitively a combination of approaches would seem to be desirable.

4.4.2 Working with adolescents and their parents/families

Conceptualising adolescent psychopathology in attachment terms has implications for assessment and treatment of adolescents. It indicates the need for assessment to encompass understanding of early attachment relationships to caregivers and how these may influence current relationships with peers and significant others. The possible deficiencies of relying upon self-report measures with clinical adolescents, particularly those with deactivating

strategies, is documented here and in other studies (Field et al, 1991; Scott Brown, 1999). This may particularly be important with eating disordered adolescents who may considerably downplay their difficulties. Clinicians need, therefore, to assess creatively utilising information from a range of sources, counterbalancing this with adolescents' need for confidentiality and respect (Anderson and Dartington (eds), 1998).

The present study indicates a range of risk factors that may be indicative of severe adolescent disturbance. Disorganised attachment status, perhaps as a result of early maltreatment and hypothesised accompanying cognitive dissociations (Main and Hesse, 1990) may be the most helpful indicators of severe multiple psychopathologies. It may be important to assess for these directly using measures such as the Dissociative Experiences Scale (DES – Bernstein and Puttnam, 1986) alongside listening for evidence of distortion in the narratives of adolescent patients.

Also important to adolescent pathology may be current difficulties such as parental conflict, poor family functioning, impoverished peer and sibling relationships and parental mental health problems. To these one should add further vulnerability factors such as genetic susceptibility or socio-economic difficulties, not covered within an attachment paradigm (Brown and Harris, 1993; Rutter, 1995). Types of intervention with adolescents with eating disorders and clinical depression should be moulded to fit their particular attachment needs: with hyperactivating (preoccupied) adolescents in weakening their dependency on attachment figures and tendency to dwell on negative experiences and with deactivating (dismissing) adolescents, encouraging them to become aware of their tendency to shun closeness and cut off from feelings. With more disorganised adolescents (hypothesised to be of more 'borderline' typology) the most important need may be for appropriate therapeutic 'containment' (Bion, 1962) to withstand repeated attacks and testing from the adolescent. Such interventions can be undertaken within a range of different psychological paradigms, including cognitive-behavioural (Beck, Rush, Shaw and Emery, 1979), psychodynamic (Williams, 1997, 1998) and cognitive-analytic (Ryle 1995). It can also be done through group work or family therapy (Dare et al., 1990; Kuntz, Grize and Yates, 1992).

The study seems also to support literature advocating family work/work with parents of adolescents, as part of the treatment package of young women with eating disorders and depression (Dare et al., 1990; Kuntz et al, 1992), as family dynamics may be either enmeshed or conflictual/neglectful. Whilst there are many programmes and support groups for parents of pre-school children (e.g. Webster-Stratton, 1994), there is far less available for parents of adolescents, despite adolescence being a time of potential family stress (Hill, 1993). Treatment that incorporates help for parents and/or parental support groups may therefore be highly beneficial.

Adolescence is a potentially critical time for clinical intervention, when preventative work can take place which may considerably reduce adult pathologies and the resultant drain on Adult Mental Health services. In the climate of increased demand for clinical effectiveness (Parry and Richardson, 1996; Hall and Firth-Cozens, 2000) and preventative practice, adolescents are a key age group to target. The importance of this has, indeed, been recognised in the recent government initiatives for increased resource allocation.

4.5 Directions for future research

There is clearly a great need for further research to be undertaken with adolescents with eating disorders and depression, and indeed with all clinical and more resilient adolescent groups. There is a particular need for the further development of psychometrically robust and standardised measures of attachment specific to this age-group. Further research identifying protective and risk factors in the development of adolescent psychopathology will be a crucial next step, as will research that can attribute greater degrees of causation (Cicchetti and Cohen, 1995). There is also a need for more qualitative research.

Particular areas highlighted for further work from the present study seem to be:

- Differentiation between attachment patterns in adolescents with eating disorders, clinical depression and other clinical adolescent groups.

- Further investigation of neglectful/abusive early experience in the aetiology of adolescent

depression and enmeshment in the aetiology of adolescent eating disorders.

- Further investigation of correlations between self-report data and AAI scores among parents of clinical adolescents

And, most importantly, perhaps:

- Further work on the interesting hypothesised correlations between early maltreatment/frightening behaviour and disorganised attachment in infancy, dissociation and cognitive distortion in early childhood and multiple pathologies in adolescence.

- Further investigation of the hypothesised connection between maltreatment, disorganisation, dissociation and adolescent-onset BPD.

4.6 Conclusions

Attachment Theory is one theoretical paradigm that cannot possibly explain adolescent psychopathology single-handedly. Attachment style does not seem fixed, but rather to change throughout the lifespan as a result of developmental experience well into adulthood (Sroufe et al., 1999). Attachment categories are less comfortably distinct than we would like to believe. Nonetheless, this study has suggested that reported early and current attachment disturbances may be significantly linked to psychopathology in girls with eating disorders and clinical depression. The potential importance of poor maternal bonding, impoverished family functioning, reported early abusive/frightening experiences, underdeveloped reflective capacities and the cognitive distortions that may accompany them, have all been implicated in the aetiology of adolescent disturbance.

Bowlby never intended to provide a linear theory to explain all psychopathologies. What he wanted, was to produce a conceptual framework that could quantify and measure the impact of early experience and that could incorporate knowledge from biology, neuroscience and developmental psychology to do so. He aimed to redress the exclusively 'internal world' view of psychopathology held by his fellow psychoanalysts and to optimistically indicate therapeutic pathways towards illness prevention and mental health restoration.

Surely the concept of 'Attachment' has provided an appropriate theoretical paradigm to this end and, in its encapsulation and careful measurement of early patterns of relating, has furthered our understanding both of normal adolescent functioning and pathological breakdown. It is now the task of mental health professionals to utilise this 'secure' theoretical base by intervening proactively with children, adolescents, parents and families to address the quality of attachment relationships, thereby perhaps preventing more "ghosts" (Fraiberg et al., 1975) entering the nurseries of future generations.

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APPENDICES

APPENDIX 1:
PARTICIPANT INFORMATION

Appendix 1:1 Participant profile – Eating disordered group

Participant	Age	Region	Ethnicity	Parental occupations	Diagnosis	Length of contact with mental health services
1	16	Home Counties	White	F = Royal Navy officer M= legal secretary	Anorexia Nervosa/ Clinical Depression	3 months
2	17	Home Counties	White	F= IT programmer M=Receptionist	Anorexia Nervosa	4 months
3	15	Home Counties	White	F= Police officer M= Teacher	Bulimia Nervosa	3 months
4	13	Home Counties	White	F= Businessman M=Teacher	Anorexia Nervosa	4 months
5	13	Home Counties	White	F= Printer M=Housewife	Anorexia Nervosa	2 months
6	15	Outer London	White	F=Architect M=Occupational Therapist	Bulimia Nervosa	1 month/less
7	16	Home counties	White	F= Salesman M = Hairdresser	Bulimia Nervosa	1 month/less
8	18	Inner London	White	F=Plumber M=Carer	Anorexia Nervosa	6 months
9	17	Inner London	White	F=Businessman M=Housewife	Anorexia Nervosa/Clinical Depression	5 months
10	19	Inner London	White	F= Accountant M=IT programmer	Bulimia Nervosa	5 months

Appendix 1: 2 - Participant profile: Depressed Group

Participant	Age	Region	Ethnicity	Parental occupations (where given)	Dual Diagnosis/other info (non-interviewees)?	Length of contact with mental health services
1	15	Home Counties	White	F=Builder M=Care worker	No	4 months
2	16	Home Counties	White	F=Managing Director M=Caterer	Anxiety/phobias	1 month/less
3	17	Home Counties	White	F=Builder M=classroom assistant	No	2 months
4	17	Home Counties	White	F=Banker M=Housewife	No	2 months
5	18	Inner London	Jewish /Israeli	F=Rabbi M=Housewife	Chronic fatigue; suicidal	6 months
6	15	Outer London	Indian	F=Restauranteur M=Volunteer carer	Chronic fatigue/somatic	5 months
7	17	Inner London	White	F= IT consultant M=Doctor	No	6 months
8	13	Inner London	White	F=painter/ decorator M = housewife	Self-harm; suicidal; Borderline personality disorder	2 months
9	19	Inner London	Indian	F=Project Manager M=Housewife	No	3 months
10	15	Inner London	White	F= Teacher M=Copy-Editor	No	1 month/less

Appendix 1: 3 - Participant profile: control group

Participant	Age	Region	Ethnicity	Parental occupations (where given)
1	14	Home Counties	White	F = Manager M = Teacher
2	15	Home Counties	White	F = teacher M = copy-editor
3	16	Home Counties	White	F = Teacher M = copy editor
4	15	Home Counties	White	F= Engineer M=Nurse
5	15	Home Counties	South American	F=Accountant M= Housewife
6	14	Home Counties	White	M = Nurse (Father dead)
7	16	Outer London	White	F = Housing Manager M = Administrator
8	14	Home Counties	White	F = Solicitor M=Housewife
9	17	Home Counties	White	F=Accountant M=Physiotherapist
10	16	Outer London	White	F= Insurance broker M=Social Worker

Appendix 1: 4 - Classification of Parental Occupations

Skilled/Professional	Semi-professional	Manual/unskilled
Teacher	Administrator	Builder
Manager	Legal secretary	Care Worker
Copy-editor	Receptionist	Classroom assistant
Engineer	Salesman	Hairdresser
Doctor	Caterer	Plumber
Nurse	Restauranteur	Carer
Accountant		Volunteer carer
Housing Manager		Painter/decorator
Solicitor		Printer
Physiotherapist		
Social Worker		
Insurance broker		
Managing Director		
Rabbi		
Banker		
IT consultant		
Project Manager		
Royal Navy officer		
Police officer		
Businessman		
Architect		
Occupational Therapist		
IT programmer		

APPENDIX 2: STIRLING EATING DISORDER SCALES

STIRLING EATING DISORDER SCALES

NAME .....

INSTRUCTIONS

This questionnaire contains 80 statements about thoughts and feelings. Read each statement carefully and decide if it applies to you or not. If the statement applies to you usually or all the time tick ✓ the True circle O. If the statement rarely or never applies to you tick ✓ the False circle O. If you make a mistake cross it out ✗ and give your correct answer. Do not spend a long time thinking about each statement – just give your first reaction. There are no right or wrong answers. There are two pages of statements – please be sure to answer all of them. Complete Page 1 first and then Page 2.

	TRUE	FALSE
I tend to bottle up my emotions rather than make a scene	O	O
At times I think I am no good at all	O	O
I often want to injure myself	O	O
I can pretty much decide what happens in my life	O	O
I find myself preoccupied with food	O	O
I eat the same food day after day	O	O
I feel satisfied with my eating patterns	O	O
I eat a lot of food even when I'm not hungry	O	O
I find it difficult to ask personal questions	O	O
I have a positive attitude towards myself	O	O
I believe I am a bad person	O	O
My life is determined by my own actions	O	O
When I eat anything I feel guilty	O	O
I eat low calorie foods all the time	O	O
When I binge I have a sense of unreality	O	O
I never eat controllably	O	O
I feel I can ask my parents/friends not to nag me	O	O
I feel I am not as popular as other people of my age	O	O
I often feel angry with myself	O	O
Little in this world controls me – I usually do what I decide to do	O	O
High carbohydrate foods make me feel nervous	O	O
I often hide food rather than eat it	O	O
When I binge I feel disgusted with myself	O	O
I hide the evidence of my binges (eg food wrappers)	O	O
I feel confident going into a social gathering	O	O
I believe my parents are proud of me	O	O
I feel ashamed of myself	O	O
I feel I live according to other people's rules	O	O
I believe I am allergic to many foods	O	O
I cut my food into very small pieces in order to eat more slowly	O	O
I am not worried about my binging	O	O
I take laxatives in order to get rid of the food I have eaten	O	O
I am afraid of people being angry with me	O	O
I have a strong sense of self-worth	O	O
I do not behave the way I should	O	O
I feel I am in control of my body	O	O
I can eat sweets without feeling anxious	O	O
I weigh myself after meals	O	O
I feel ashamed of the amount of food I can eat	O	O
I try to diet but always lose control	O	O

STIRLING EATING DISORDER SCALES

NAME .....

INSTRUCTIONS

As you did for Page One, read each statement carefully and decide if it applies to you or not. If the statement applies to you usually or all the time tick ✓ the True circle O. If the statement rarely or never applies to you tick ✓ the False circle O. If you make a mistake cross it out ✗ and give your correct answer. Do not spend a long time thinking about each statement – just give your first reaction. There are no right or wrong answers. When you have completed this page go back and check that you have answered all the statements on both pages.

	TRUE	FALSE
If someone is unfair to me, I feel I can tell him/her	O	O
I have little respect for myself	O	O
I have very hostile feelings towards myself	O	O
I feel my family have control over me	O	O
I must be very controlled in my eating habits	O	O
I count the calories of everything I eat	O	O
I hate myself after binging	O	O
I intentionally vomit after eating	O	O
I am an assertive person	O	O
I feel proud of my achievements	O	O
I have very little to feel guilty about	O	O
I often feel I am controlled by something outside of myself	O	O
If I overeat a little I feel frightened	O	O
I eat rich, high calorie foods	O	O
I feel frightened if I cannot get rid of the food I have eaten either by vomiting, laxatives or fasting	O	O
I always eat a lot in secret	O	O
I feel I cannot tell people when they have hurt me	O	O
I do not feel very clever	O	O
I should be a better person	O	O
I feel my boyfriend/girlfriend/spouse/parent has a lot of control over me	O	O
I can overeat a little and not feel nervous	O	O
I keep to a very strict diet regime	O	O
I feel my eating patterns control my life	O	O
I often eat so much my stomach hurts	O	O
I feel I can assert myself with people in authority	O	O
I feel I am not as attractive as other people my age	O	O
I deserve to be punished	O	O
My health is not under control	O	O
I believe I do not need as much food as other people	O	O
I often eat in front of others	O	O
I believe I can stop eating when I want to	O	O
I lie about the large amount of food I eat	O	O
I tend to sulk rather than have an argument	O	O
I have a nice personality	O	O
I have very little to be self-critical about	O	O
Other people control my life	O	O
I feel disgusted with myself when I eat anything	O	O
I cook for others but avoid eating with them	O	O
I feel that my eating patterns are out of control	O	O
I rarely binge	O	O

Appendix 2b: Clinical cut-off scores for the Stirling Eating Disorder Scales (Williams and Power, 1996)

SCALE	CUT-OFF SCORES	
	Anorexic	**Bulimic**
Anorexic Dietary Cognitions	9.0	9.0
Anorexic Dietary Behaviour	14.0	14.0
Bulimic Dietary Cognitions	17.0	17.0
Bulimic Dietary Behaviour	14.0	14.0
Perceived External Control	9.0	8.0
Low Assertiveness	15.0	15.0
Low Self-Esteem	14.0	14.0
Self Directed Hostility	12.0	12.0
TOTAL CUT-OFF	**104**	**103**

APPENDIX 3

YOUTH SELF-REPORT FOR AGES 11–18

Please Print

For office use only
ID #

YOUR FULL NAME: FIRST MIDDLE LAST

YOUR SEX ☐ Boy ☐ Girl

YOUR AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo. _____ Date _____ Yr. ____

YOUR BIRTHDATE Mo. _____ Date _____ Yr. ____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

PARENTS' USUAL TYPE OF WORK, even if not working now *(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK _____

Please fill out this form to reflect *your* views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4.

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of your age, about how much time do you spend in each?			Compared to others of your a how well do you do each one?		
	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐

II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, cars, crafts, etc. (Do *not* include listening to radio or TV.)

☐ None

	Compared to others of your age, about how much time do you spend in each?			Compared to others of your a how well do you do each one?		
	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams or groups you belong to.

☐ None

	Compared to others of your age, how active are you in each?		
	Less Active	Average	More Active
a. _____	☐	☐	☐
b. _____	☐	☐	☐
c. _____	☐	☐	☐

IV. Please list any jobs or chores you have. For example: paper route, babysitting, making bed, working in store, etc. (Include ***both*** paid and unpaid jobs and chores.)

☐ None

	Compared to others of your age, how well do you carry them out?		
	Below Average	Average	Above Average
a. _____	☐	☐	☐
b. _____	☐	☐	☐
c. _____	☐	☐	☐

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V. 1. About how many close friends do you have? (Do *not* include brothers & sisters) ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week do you do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of your age, how well do you:

	Worse	About the same	Better	
a. Get along with your brothers & sisters?	☐	☐	☐	☐ I have no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Get along with your parents?	☐	☐	☐	
d. Do things by yourself?	☐	☐	☐	

VII. Performance in academic subjects. ☐ I do not attend school because _____

Check a box for each subject that you take	Failing	Below Average	Average	Above Average
a. English or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
Other academic subjects – for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Do you have any illness, disability, or handicap? ☐ No ☐ Yes—please describe:

Please describe any concerns or problems you have about school:

Please describe any other concerns you have:

Please describe the best things about yourself:

Below is a list of items that describe kids. For each item that describes you ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of you. Circle the ***1*** if the item is ***somewhat or sometimes true*** of you. If the item is ***not true*** of you, circle the ***0***.

Please Print **0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True**

0 1 2 1. I act too young for my age
0 1 2 2. I have an allergy (describe): _____
_____
_____
0 1 2 3. I argue a lot
0 1 2 4. I have asthma
0 1 2 5. I act like the opposite sex
0 1 2 6. I like animals
0 1 2 7. I brag
0 1 2 8. I have trouble concentrating or paying attention
0 1 2 9. I can't get my mind off certain thoughts (describe): _____
_____
_____
0 1 2 10. I have trouble sitting still
0 1 2 11. I'm too dependent on adults
0 1 2 12. I feel lonely
0 1 2 13. I feel confused or in a fog
0 1 2 14. I cry a lot
0 1 2 15. I am pretty honest
0 1 2 16. I am mean to others
0 1 2 17. I daydream a lot
0 1 2 18. I deliberately try to hurt or kill myself
0 1 2 19. I try to get a lot of attention
0 1 2 20. I destroy my own things
0 1 2 21. I destroy things belonging to others
0 1 2 22. I disobey my parents
0 1 2 23. I disobey at school
0 1 2 24. I don't eat as well as I should
0 1 2 25. I don't get along with other kids
0 1 2 26. I don't feel guilty after doing something I shouldn't
0 1 2 27. I am jealous of others
0 1 2 28. I am willing to help others when they need help
0 1 2 29. I am afraid of certain animals, situations, or places, other than school (describe): _____
_____
_____
0 1 2 30. I am afraid of going to school
0 1 2 31. I am afraid I might think or do something bad
0 1 2 32. I feel that I have to be perfect
0 1 2 33. I feel that no one loves me
0 1 2 34. I feel that others are out to get me
0 1 2 35 I feel worthless or inferior
0 1 2 36. I accidentally get hurt a lot
0 1 2 37. I get in many fights
0 1 2 38. I get teased a lot
0 1 2 39. I hang around with kids who get in trouble
0 1 2 40. I hear sounds or voices that other people think aren't there (describe): _____
_____
_____
0 1 2 41. I act without stopping to think
0 1 2 42. I would rather be alone than with others
0 1 2 43. I lie or cheat
0 1 2 44. I bite my fingernails
0 1 2 45. I am nervous or tense
0 1 2 46. Parts of my body twitch or make nervous movements (describe):
_____
_____
0 1 2 47. I have nightmares
0 1 2 48. I am not liked by other kids
0 1 2 49. I can do certain things better than most kids
0 1 2 50. I am too fearful or anxious
0 1 2 51. I feel dizzy
0 1 2 52. I feel too guilty
0 1 2 53. I eat too much
0 1 2 54. I feel overtired
0 1 2 55. I am overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feel sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe):
_____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____
_____
0 1 2 57. I physically attack people
0 1 2 58. I pick my skin or other parts of my body (describe): _____
_____
_____
0 1 2 59. I can be pretty friendly
0 1 2 60. I like to try new things
0 1 2 61. My school work is poor
0 1 2 62. I am poorly coordinated or clumsy
0 1 2 63. I would rather be with older kids than with kids my own age

Please see other si

0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 64. I would rather be with younger kids than with kids my own age
0 1 2 65. I refuse to talk
0 1 2 66. I repeat certain acts over and over (describe): _____
_____
_____
0 1 2 67. I run away from home
0 1 2 68. I scream a lot
0 1 2 69. I am secretive or keep things to myself
0 1 2 70. I see things that other people think aren't there (describe): _____
_____
_____
0 1 2 71. I am self-conscious or easily embarrassed
0 1 2 72. I set fires
0 1 2 73. I can work well with my hands
0 1 2 74. I show off or clown
0 1 2 75. I am shy
0 1 2 76. I sleep less than most kids
0 1 2 77. I sleep more than most kids during day and/or night (describe): _____
_____
_____
0 1 2 78. I have a good imagination
0 1 2 79. I have a speech problem (describe): _____
_____
_____
_____
0 1 2 80. I stand up for my rights
0 1 2 81. I steal at home
0 1 2 82. I steal from places other than home
0 1 2 83. I store up things I don't need (describe):
_____
_____
0 1 2 84. I do things other people think are strange (describe): _____
_____
_____
0 1 2 85. I have thoughts that other people would think are strange (describe): _____
_____
_____
_____
0 1 2 86. I am stubborn
0 1 2 87. My moods or feelings change suddenly
0 1 2 88. I enjoy being with other people
0 1 2 89. I am suspicious
0 1 2 90. I swear or use dirty language
0 1 2 91. I think about killing myself
0 1 2 92. I like to make others laugh
0 1 2 93. I talk too much
0 1 2 94. I tease others a lot
0 1 2 95. I have a hot temper
0 1 2 96. I think about sex too much
0 1 2 97. I threaten to hurt people
0 1 2 98. I like to help others
0 1 2 99. I am too concerned about being neat or clean
0 1 2 100. I have trouble sleeping (describe): _____
_____
_____
0 1 2 101. I cut classes or skip school
0 1 2 102. I don't have much energy
0 1 2 103. I am unhappy, sad, or depressed
0 1 2 104. I am louder than other kids
0 1 2 105. I use alcohol or drugs for nonmedical purposes (describe): _____
_____
_____
_____
0 1 2 106. I try to be fair to others
0 1 2 107. I enjoy a good joke
0 1 2 108. I like to take life easy
0 1 2 109. I try to help other people when I can
0 1 2 110. I wish I were of the opposite sex
0 1 2 111. I keep from getting involved with others
0 1 2 112. I worry a lot

Please write down anything else that describes your feelings, behavior, or interests

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS

APPENDIX 4

ADULT SELF REPORT FORM

Below is a list of items that describe people. For each item, please circle 0, 1, or 2 to describe yourself over the past 6 months. Please answer all items as well as you can, even if some do not seem to apply to you.

0 = Not true 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. I act too young for my age
0 1 2 2. I make good use of my opportunities
0 1 2 3. I argue a lot
0 1 2 4. I work up to my ability
0 1 2 5. I act like the opposite sex
0 1 2 6. I use drugs [other than alcohol] for non medical purposes (describe)
.....
0 1 2 7. I brag
0 1 2 8. I have trouble concentrating or paying attention too long
0 1 2 9. I can't get my mind off certain thoughts: (describe)
.....
.....
0 1 2 10. I have trouble sitting still
0 1 2 11. I am too dependent on others
0 1 2 12. I feel lonely
0 1 2 13. I feel confused or in a fog
0 1 2 14. I cry a lot
0 1 2 15. I am pretty honest
0 1 2 16. I am mean to others
0 1 2 17. I daydream a lot
0 1 2 18. I deliberately try to hurt or kill myself
0 1 2 19. I try to get a lot of attention
0 1 2 20. I destroy my things
0 1 2 21. I destroy things belonging to others
0 1 2 22. I worry about my future
0 1 2 23. I break rules at school, work, or elsewhere
0 1 2 24. I don't eat as well as I should
0 1 2 25. I don't get along with other people
0 1 2 26. I don't feel guilty after doing something shouldn't
0 1 2 27. I am jealous of others
0 1 2 28. I get along badly with my family
0 1 2 29. I am afraid of certain animals, situations or places (describe)
.....
.....
0 1 2 30. My relations with the opposite sex are poor
0 1 2 31. I am afraid I might think or do something bad
0 1 2 32. I feel that I have to be perfect
0 1 2 33. I feel that no one loves me
0 1 2 34. I feel that others are out to get me
0 1 2 35. I feel worthless or inferior
0 1 2 36. I accidentally get hurt a lot
0 1 2 37. I get in many fights
0 1 2 38. I get teased a lot
0 1 2 39. I hang around with others who get in trouble
0 1 2 40. I hear sounds or voices that other people think aren't there (describe)
.....
.....
0 1 2 41. I am impulsive or act without thinking
0 1 2 42. I would rather be alone than with others
0 1 2 43. I lie or cheat
0 1 2 44. I bite my fingernails
0 1 2 45. I am nervous or tense
0 1 2 46. Parts of my body twitch or make nervous movements (describe)
.....
.....
0 1 2 47. I lack self confidence
0 1 2 48. I am not liked by others
0 1 2 49. I can do certain things better than other people
0 1 2 50. I am too fearful or anxious
0 1 2 51. I feel dizzy or light headed
0 1 2 52. I feel too guilty
0 1 2 53. I eat too much
0 1 2 54. I feel overtired
0 1 2 55. I am overweight
56. Physical problems without known medical cause:
0 1 2 a) Aches or pains (not stomach or headaches)
0 1 2 b) Headaches
0 1 2 c) Nausea, feels sick
0 1 2 d) Problems with eyes [not if corrected by glasses] (describe)
.....
0 1 2 e) Rashes or other skin problems
0 1 2 f) Stomach aches
0 1 2 g) Vomiting, throwing up
0 1 2 h) Heart pounding or racing
0 1 2 i) Numbness or tingling in body parts
0 1 2 j) Other (describe)
.....

PLEASE MAKE SURE YOU ANSWER ALL THE ITEMS ON THIS PAGE AND THE NEXT PAGE.

ADULT SELF REPORT FORM

0 = Not true 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. I physically attack people
0 1 2 58. I pick my skin or other parts of my body (describe)
.....
.....
0 1 2 59. I fail to finish things I do
0 1 2 60. There is very little that I enjoy
0 1 2 61. My school work or job performance is poor
0 1 2 62. I am poorly co-ordinated or clumsy
0 1 2 63. I would rather be with older people than with people of my own age
0 1 2 64. I would rather be with younger people than with people of my own age
0 1 2 65. I refuse to talk
0 1 2 66. I repeat certain acts over and over (describe)
.....
.....
0 1 2 67. I have trouble making or keeping friends
0 1 2 68. I scream and yell a lot
0 1 2 69. I am secretive or keep things to myself
0 1 2 70. I see things that other people think aren't there (describe)
.....
.....
0 1 2 71. I am self-conscious or easily embarrassed
0 1 2 72. I set fires
0 1 2 73. I meet my responsibilities to my family
0 1 2 74. I show off or clown
0 1 2 75. I am shy or timid
0 1 2 76. My behaviour is irresponsible
0 1 2 77. I sleep more than most other people during the day and/or night (describe)
.....
.....
0 1 2 78. I have trouble making decisions
0 1 2 79. I have a speech problem (describe)
.....
0 1 2 80. I stand up for my rights
0 1 2 81. I worry about my job or school work (describe)
.....
.....
0 1 2 82. I steal
0 1 2 83. I store up too many things I don't need (describe)
.....
.....
0 1 2 84. I do things other people think are strange (describe)
.....
.....
0 1 2 85. I have thoughts that other people would think are strange (describe)
.....
.....
0 1 2 86. I am stubborn, sullen or irritable
0 1 2 87. My moods or feelings change suddenly
0 1 2 88. I enjoy being with other people
0 1 2 89. I am suspicious
0 1 2 90. I drink too much alcohol or get drunk
0 1 2 91. I think about killing myself
0 1 2 92. I do things that may cause me trouble with the law (describe)
.....
.....
0 1 2 93. I talk too much
0 1 2 94. I tease others a lot
0 1 2 95. I have a hot temper
0 1 2 96. I think about sex too much
0 1 2 97. I threaten to hurt people
0 1 2 98. I like to help others
0 1 2 99. I enjoy a good joke
0 1 2 100. I have trouble sleeping (describe)
.....
.....
0 1 2 101. I have a good imagination
0 1 2 102. I don't have much energy
0 1 2 103. I am unhappy, sad or depressed
0 1 2 104. I am louder than others
0 1 2 105. I like to make others laugh
0 1 2 106. I try to be fair to others
0 1 2 107. I feel that I can't succeed
0 1 2 108. I like to take life easy
0 1 2 109. I like to try new things
0 1 2 110. I wish I were of the opposite sex
0 1 2 111. I keep from getting involved with others
0 1 2 112. I worry a lot
0 1 2 113. I am too concerned about how I look
0 1 2 114. I fail to pay my debts or meet other financial responsibilities
0 1 2 115. I have nightmares
0 1 2 116. I worry about my relations with the opposite sex

117. *In the past 6 months*, about how many times per day did you use tobacco (including smokeless tobacco)? ..... times per day

118. *In the past 6 months*, on how many days were you drunk? ..... days.

119. *In the past six months*, how many days did you use drugs for non medical purposes (including marijuana, glue, cocaine, and any other drugs)? .....days

PLEASE MAKE SURE YOU HAVE ANSWERED ALL ITEMS

01-18-39 (2)

APPENDIX 5

NAME : . . . . . DATE : . . . . . .

P B I

This questionnaire lists various attitudes and behaviours of parents. As you remember your mother/father in your first 16 years would you place a tick in the most appropriate boxes next to each question

	very like	moderately like	moderately unlike	very unlike
Spoke to me with a warm and friendly voice				
Did not help me as much as I needed				
Let me do those things I liked doing				
Seemed emotionally cold to me				
Appeared to understand my problems				
Was affectionate to me				
Liked me to make my own decisions				
Did not want me to grow up				
Tried to control everything I did				
Invaded my privacy				
Enjoyed talking things over with me				
Frequently smiled at me				
Tended to baby me				
Did not seem to understand what I needed or wanted				
Let me decide things for myself				
Made me feel I was not wanted				
Could make me feel better when I was upset				
Did not talk with me very much				
Tried to make me dependent on her/him				
Felt I could not look after myself unless she/he was around				
Gave me as much freedom as I wanted				
Let me go out as often as I wanted				
Was overprotective of me				
Did not praise me				
Let me dress in any way I pleased				

APPENDIX 6

S-I. T.A.

ATTITUDE AND FEELINGS SURVEY

Directions: Listed below are a number of statements which best describe various feelings, attitudes, and behaviors that people have. Read each statement and then mark on your sheet:

(a) if the statement is always true for you or you strongly agree with it,

(b) if the statement is usually true for you or you generally agree with it,

(c) if the statement is sometimes true for you or you slightly agree with it,

(d) if the statement is hardly ever true for you or you generally disagree with it.

(e) if the statement is never true for you or you strongly disagree with it.

Please answer all of the questions. If you have difficulty answering a particular question, choose the response which is closest to your feelings on that item, even though you may not feel strongly one way or another.

Please use a #2 pencil to complete the answer sheet and erase completely any answer you may wish to change. In marking your choices, be sure the number of the statement you have just read is the same number you are marking on the answer sheet.

1. Sometimes my parents are so overprotective, I feel smothered.

2. I sometimes feel so powerful that it seems like there is no feat which is too difficult for me to conquer.

3. Being alone is a very scary idea for me.

4. Often I don't understand what people want out of a close relationship.

5. I enjoy being by myself and with others approximately the same.

6. I can't wait for the day that I can live on my own and am free from my parents.

7. Sometimes it seems that people really want to hurt me.

8. I worry about death a lot.

9. Most parents are overcontrolling and don't really want their children to grow up.

10. Sometimes I think how nice it was to be a young child when someone else took care of my needs.

11. I am friendly with several different types of people.

12. I don't see the point of most warm, affectionate relationships.

13. I particularly enjoy looking at my own body in the mirror.

14. One of my parents knows me so well they almost always know what I am thinking.

15. If I told someone about the troubles I have, they would probably not understand.

16. I do best when I'm by myself and don't have other people around to bother me.

17. Even when I'm very close to another person, I feel I can be myself.

18. Usually, when I'm doing something with my friends, I act like a leader.

19. I feel lonely when I'm away from my parents for any extended period of time.

20. I frequently worry about being rejected by my friends.

21. My friends and I have some common interests and some differences.

22. I can't feel that love has much of a place in my life.

23. I frequently worry about breaking up with my boyfriend girlfriend.

24. My parents seem much more concerned about their own plans than they do about mine.

25. Even with my good friends I can't count on them to be there if I really needed them.

26. I feel that other people interfere with my ability "to do my own thing".

27. Being close to someone else is uncomfortable.

28. Although my best friend does things I do not like, I still care about him/her a great deal.

29. Considering most of the people I know, I find myself comparatively better off.

30. I often feel rebellious towards things my parents tell me to do.

31. Sometimes I amaze myself with my own capabilities and talents.

32. My life is fulfilled without having best friends.

33. Although I'm like my close friends in some ways, we're so different from each other in other ways.

34. I am quite worried that there might be a nuclear war in the next decade that would destroy much of this world.

35. I feel that other people admire and look up to me.

36. Friendship isn't worth the effort it takes.

37. While I like to get along well with my friends, if I disagree with something they're doing, I usually feel free to say so.

38. The teacher's opinion of me as a person is very important to me.

39. My parents seem very uninterested in what's going on with me.

40. I feel overpowered or controlled by people around me.

41. I think it's really silly when people cry at the end of an emotional film.

42. I believe that God looks over and protects me from danger.

43. It sometimes seems that my parents wish they hadn't ever had me.

44. I don't really need anyone.

45. I'm quite worried about the possibility of one of my parents dying.

46. When I think of the people that are most important to me I wish I could be with them more and be closer to them emotionally.

47. It's hard for me to really trust anyone

48. Even when they don't say it, I can sometimes tell that people admire me by the look in their eyes.

49. I don't really love anyone.

50. My parents keep close tabs on my whereabouts.

51. I feel my parents' roles restrict my freedom too much.

52. People sometimes seem amazed by their own abilities.

53. No one seems to understand me.

54. Before I go to sleep at night, I sometimes feel lonely and wish there were someone around to talk to or just to be with.

55. If I let myself get close to someone else I would probably get burned.

56. God knows my life, I will go where he leads me.

57. Other people are easily impressed by me.

58. Sometimes it seems my parents really hate me.

59. As long as I don't depend on anyone, I can't get hurt.

60. Knowing that other people find my physical appearance attractive is very pleasing to me.

61. I often sense admiration from those around me.

62. At home, I seem to be "in the way" a lot.

63. The idea of going to a large party where I would not know anyone is a scary one for me.

64. I feel special, compared to other people.

65. In my group of friends, I am often the centre of attention.

66. I preferred the younger years of life when I could rely more on my parents for guidance to get along.

67. I usually get positive "vibes" from other people regarding how they feel about me.

68. I can't have much of a need for close friendships with others.

69. I worry about being disapproved of by my teachers.

70. Other people seem to be impressed by my capabilities.

71. I would like to always live in the same town as my parents and siblings so we could spend a lot of time together.

72. My personal plans are more important than my relationships.

73. I am looking forward to getting out from under the rule of my parents.

74. I would get upset if I found out my teacher was mad at me or disappointed in me.

APPENDIX 7 – PARENT VERSION

ADULT RECIPROCAL ATTACHMENT QUESTIONNAIRE

In this questionnaire, you will find questions about your relationship to one special person in your life. We call this special person your "attachment figure". By this we mean:

- **Most likely, the person you are living with or romantically involved with.**
- **The person you'd most likely expect to turn to for comfort, help, advice, love or understanding.**
- **The person you'd be most likely to depend on, and who may depend on you for some things.**

This person may be your partner or another special friend. You may have several people in your life whom you are close to in different ways, or it may be difficult to think of one person who means that much to you.

To answer the following questions, think of **the person you feel closest to now.** This person is your **attachment figure**, even if the descriptions don't all seem to fit.

Is there someone in your life now whom you would describe as your attachment figure?

YES **NO** (please circle)

Relationship to your attachment figure:

This person is my _____

****

On the following pages you will find a series of statements concerning your relationship with your attachment figure. In each instance you are asked to rate how strongly you agree that the statement is typical of you. Please think about each question and answer carefully, but do not worry if some questions are hard to answer exactly: trust your own judgements. Remember, this questionnaire is not a test; there are no right or wrong answers. The questions simply describe different relationships. Thank you for your help.

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

1. I turn to my attachment figure for many things, including comfort and reassurance 1 2 3 4 5
2. I wish there was less anger in my relationship with my attachment figure 1 2 3 4 5
3. I put my attachment figure's needs before my own. 1 2 3 4 5
4. I get frustrated when my attachment figure is not around as much as I would like 1 2 3 4 5

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

5. I feel that it is best not to depend on my attachment figure 1 2 3 4 5

6. I want to get close to my attachment figure but I keep pulling back 1 2 3 4 5

7. I often feel too dependent on my attachment figure 1 2 3 4 5

8. I can't get on with my work if my attachment figure has a problem 1 2 3 4 5

9. I enjoy taking care of my attachment figure ... 1 2 3 4 5

10. I don't object when my attachment figure goes away for a few days 1 2 3 4 5

11. I'm confident that my attachment figure will try to understand my feelings 1 2 3 4 5

12. I wish that I could be a child again and be taken care of by my attachment figure 1 2 3 4 5

13. I worry that my attachment figure will let me down 1 2 3 4 5

14. I wouldn't want my attachment figure relying on me 1 2 3 4 5

15. I resent it when my attachment figure spends time away from me 1 2 3 4 5

16. I have to have my attachment figure with me when I'm upset 1 2 3 4 5

17. I rely on myself and not on my attachment figure to solve my problems 1 2 3 4 5

18. When I'm upset, I'm confident my attachment figure will be there to listen to me 1 2 3 4 5

19. I usually discuss my problems and concerns with my attachment figure 1 2 3 4 5

20. I feel abandoned when my attachment figure is away for a few days 1 2 3 4 5

21. I have a terrible fear that my relationship with my attachment figure will end 1 2 3 4 5

22. I do not need my attachment figure to take care of me 1 2 3 4 5

23. My attachment figure only seems to notice me when I'm angry 1 2 3 4 5

24. I talk things over with my attachment figure ... 1 2 3 4 5

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

25. It's easy for me to be affectionate with my attachment figure 1 2 3 4 5

26. I expect my attachment figure to take care of his/her own problems 1 2 3 4 5

27. I'm afraid that I will lose my attachment figure's love 1 2 3 4 5

28. I feel lost if I'm upset and my attachment figure is not around 1 2 3 4 5

29. I'm furious that I don't get any comfort from my attachment figure 1 2 3 4 5

30. I'm so used to doing things on my own that I don't ask my attachment figure for help 1 2 3 4 5

31. I'm confident that my attachment figure will always love me 1 2 3 4 5

32. I'm never certain about what I should do until I talk to my attachment figure 1 2 3 4 5

33. I would be helpless without my attachment figure 1 2 3 4 5

34. Things have to be really bad for me to ask my attachment figure for help 1 2 3 4 5

35. I get really angry at my attachment figure because I think he/she could make time for me .. 1 2 3 4 5

36. I often feel angry with my attachment figure without knowing why 1 2 3 4 5

37. I feel that the hardest thing to do is to stand on my own 1 2 3 4 5

38. I feel that there is something wrong with me because I'm remote from my attachment figure ... 1 2 3 4 5

39. I don't make a fuss over my attachment figure .. 1 2 3 4 5

40. I don't sacrifice my own needs for the benefit of my attachment figure 1 2 3 4 5

41. My attachment figure is always disappointing me 1 2 3 4 5

42. When I am anxious I desperately need to be close to my attachment figure 1 2 3 4 5

43. It makes me feel important to be able to do things for my attachment figure 1 2 3 4 5

END OF ADULT RECIPROCAL ATTACHMENT QUESTIONNAIRE. PLEASE TURN OVER AND CONTINUE. THANK YOU.

APPENDIX 7 - ADOLESCENT VERSION

RECIPROCAL ATTACHMENT QUESTIONNAIRE

In this questionnaire, you will find questions about your relationship to one special person in your life. We call this special person your "attachment figure". By this we mean:

- Most likely, the person you are living with or romantically involved with.
- The person you'd most likely expect to turn to for comfort, help, advice, love or understanding.
- The person you'd be most likely to depend on, and who may depend on you for some things.

This person may be your parent, partner or another special friend . You may have several people in your life whom you are close to in different ways, or it may be difficult to think of one person who means that much to you.

To answer the following questions, think of **the person you feel closest to now.** This person is your **attachment figure**, even if the descriptions don't all seem to fit.

Is there someone in your life now whom you would describe as your attachment figure?

YES NO (please circle)

Relationship to your attachment figure:

This person is my _____

****

On the following pages you will find a series of statements concerning your relationship with your attachment figure. In each instance you are asked to rate how strongly you agree that the statement is typical of you. Please think about each question and answer carefully, but do not worry if some questions are hard to answer exactly: trust your own judgements. Remember, this questionnaire is not a test; there are no right or wrong answers. The questions simply describe different relationships. Thank you for your help.

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

1. I turn to my attachment figure for many things, including comfort and reassurance 1 2 3 4 5
2. I wish there was less anger in my relationship with my attachment figure 1 2 3 4 5
3. I put my attachment figure's needs before my own. 1 2 3 4 5
4. I get frustrated when my attachment figure is not around as much as I would like 1 2 3 4 5

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

5.	I feel that it is best not to depend on my attachment figure	1	2	3	4	5
6.	I want to get close to my attachment figure but I keep pulling back	1	2	3	4	5
7.	I often feel too dependent on my attachment figure	1	2	3	4	5
8.	I can't get on with my work if my attachment figure has a problem	1	2	3	4	5
9.	I enjoy taking care of my attachment figure ...	1	2	3	4	5
10.	I don't object when my attachment figure goes away for a few days	1	2	3	4	5
11.	I'm confident that my attachment figure will try to understand my feelings	1	2	3	4	5
12.	I wish that I could be a child again and be taken care of by my attachment figure	1	2	3	4	5
13.	I worry that my attachment figure will let me down	1	2	3	4	5
14.	I wouldn't want my attachment figure relying on me	1	2	3	4	5
15.	I resent it when my attachment figure spends time away from me	1	2	3	4	5
16.	I have to have my attachment figure with me when I'm upset	1	2	3	4	5
17.	I rely on myself and not on my attachment figure to solve my problems	1	2	3	4	5
18.	When I'm upset, I'm confident my attachment figure will be there to listen to me	1	2	3	4	5
19.	I usually discuss my problems and concerns with my attachment figure	1	2	3	4	5
20.	I feel abandoned when my attachment figure is away for a few days	1	2	3	4	5
21.	I have a terrible fear that my relationship with my attachment figure will end	1	2	3	4	5
22.	I do not need my attachment figure to take care of me	1	2	3	4	5
23.	My attachment figure only seems to notice me when I'm angry	1	2	3	4	5
24.	I talk things over with my attachment figure ...	1	2	3	4	5

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

25. It's easy for me to be affectionate with my attachment figure 1 2 3 4 5

26. I expect my attachment figure to take care of his/her own problems 1 2 3 4 5

27. I'm afraid that I will lose my attachment figure's love 1 2 3 4 5

28. I feel lost if I'm upset and my attachment figure is not around 1 2 3 4 5

29. I'm furious that I don't get any comfort from my attachment figure 1 2 3 4 5

30. I'm so used to doing things on my own that I don't ask my attachment figure for help 1 2 3 4 5

31. I'm confident that my attachment figure will always love me 1 2 3 4 5

32. I'm never certain about what I should do until I talk to my attachment figure 1 2 3 4 5

33. I would be helpless without my attachment figure 1 2 3 4 5

34. Things have to be really bad for me to ask my attachment figure for help 1 2 3 4 5

35. I get really angry at my attachment figure because I think he/she could make time for me .. 1 2 3 4 5

36. I often feel angry with my attachment figure without knowing why 1 2 3 4 5

37. I feel that the hardest thing to do is to stand on my own 1 2 3 4 5

38. I feel that there is something wrong with me because I'm remote from my attachment figure ... 1 2 3 4 5

39. I don't make a fuss over my attachment figure .. 1 2 3 4 5

40. I don't sacrifice my own needs for the benefit of my attachment figure 1 2 3 4 5

41. My attachment figure is always disappointing me 1 2 3 4 5

42. When I am anxious I desperately need to be close to my attachment figure 1 2 3 4 5

43. It makes me feel important to be able to do things for my attachment figure 1 2 3 4 5

END OF RECIPROCAL ATTACHMENT QUESTIONNAIRE. PLEASE TURN OVER AND CONTINUE. THANK YOU.

APPENDIX 8

FACES II

Please look at each statement in turn and in the space to the left of it choose the number (1-5) of the category that BEST describes how you feel things are in your family at the moment.

So, for example with number 1, if you feel that members in your family are "supportive of each other during difficult times" **once in a while**, then you would write 2 in the space to the left of number 1, as this corresponds to the answer "Once in a while" listed at the top of the page.

Don't spend too long thinking about each statement – just give your first reaction. I am interested in what you feel. There are no right or wrong answers.

FACES II: Family Version

David H. Olson, Joyce Portner & Richard Bell

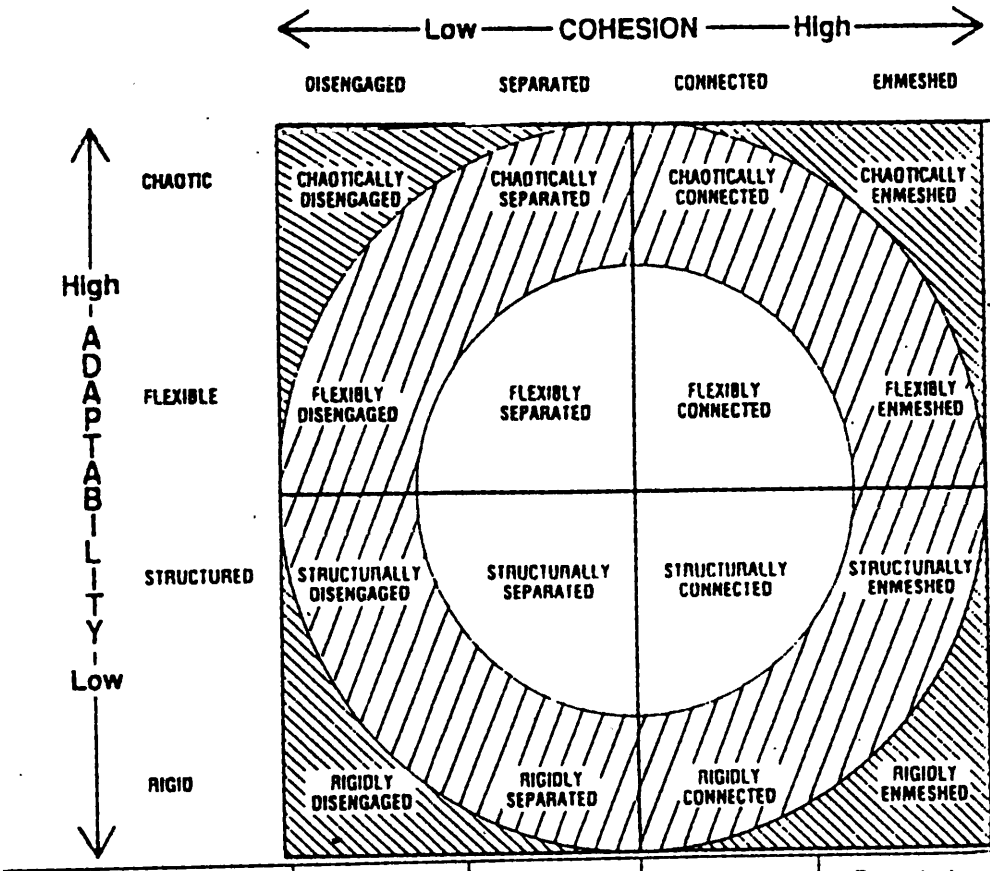
1 Almost Never	2 Once in Awhile	3 Sometimes	4 Frequently	5 Almost Always

Describe Your Family:

___ 1. Family members are supportive of each other during difficult times.
___ 2. In our family, it is easy for everyone to express his/her opinion.
___ 3. It is easier to discuss problems with people outside the family than with other family members.
___ 4. Each family member has input regarding major family decisions.
___ 5. Our family gathers together in the same room.
___ 6. Children have a say in their discipline.
___ 7. Our family does things together.
___ 8. Family members discuss problems and feel good about the solutions.
___ 9. In our family, everyone goes his/her own way.
___ 10. We shift household responsibilities from person to person.
___ 11. Family members know each other's close friends.
___ 12. It is hard to know what the rules are in our family.
___ 13. Family members consult other family members on personal decisions.
___ 14. Family members say what they want.
___ 15. We have difficulty thinking of things to do as a family.
___ 16. In solving problems, the children's suggestions are followed.
___ 17. Family members feel very close to each other.
___ 18. Discipline is fair in our family.
___ 19. Family members feel closer to people outside the family than to other family members.
___ 20. Our family tries new ways of dealing with problems.
___ 21. Family members go along with what the family decides to do.
___ 22. In our family, everyone shares responsibilities.
___ 23. Family members like to spend their free time with each other.
___ 24. It is difficult to get a rule changed in our family.
___ 25. Family members avoid each other at home.
___ 26. When problems arise, we compromise.
___ 27. We approve of each other's friends.
___ 28. Family members are afraid to say what is on their minds.
___ 29. Family members pair up rather than do things as a total family.
___ 30. Family members share interests and hobbies with each other.

APPENDIX 9

CIRCUMPLEX MODEL - Couple & Family Map



Levels of Adaptability (Change)

Chaotic
- -Lack of Leadership
- -Dramatic Role Shifts
- -Erratic Discipline
- -Too Much Change

Flexible
- -Shared Leadership
- -Role Sharing
- -Democratic Discipline
- -Change When Necessary

Structured
- -Leadership Sometimes Shared
- -Roles Stable
- -Somewhat Democratic Discipline
- -Change When Demanded

Rigid
- -Authoritarian Leadership
- -Roles Seldom Change
- -Strict Discipline
- -Too Little Change

Levels of Cohesion	Disengaged	Separated	Connected	Enmeshed
I - We Balance Closeness Loyalty Independence- Dependency	I Little Closeness Lack of Loyalty High Independence	I - we Low-Moderate Little Loyalty Interdependent More Independence Than Dependence	I - WE Moderate-High Some Loyalty Interdependent More Dependence Than Independence	WE Very High High Loyalty High Dependency

BALANCED

MID RANGE

EXT

APPENDIX 10:

ATTACHMENT INTERVIEW PROTOCOL

Attachment Interview Protocol

1. **Can you start by getting me oriented to your early family situation, and where you lived and so on? If you could tell me where you were born, whether you moved around much, what your family did at various times for a living?**

Prompts (if necessary/relevant):

Who would you say brought you up?

Did you see much of your grandparents when you were little?

Does your (relevant parent) talk to you about the grandparent(s) who died before you were born?

Did you have any brothers and sisters living in the house?

Did anyone else live with you besides your parents (and brothers/sisters)?

Anyone else who else lives with you?

2. **I'd like you to try to describe your relationship with your parents as a young child...if you could start from as far back as you can remember?**

3. Now I'd like to ask you to choose five adjectives or words that reflect your relationship with your mother * starting from as far back as you can remember in early childhood – as early as you can go, but say age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think for a minute...then I'd like to ask you why you chose them. I'll write each one down as you give it to me.

Okay....now let me go through some more questions about your descriptions of your childhood relationship with your mother. You said that your relationship with her was .....Are there any memories or incidents that come to mind with respect to.....(word) ?

....Your second word was.....Can you think of a memory or incident that would show me why you chose.....to describe the relationship? (repeat for each word chosen)

Prompts (if necessary/relevant):

Can you think of a specific memory that would illustrate how the relationship was..... .....?

That's a good general description, but I was wondering also if there was a particular time that happened, that made you think that the relationship was..... ....)?

4. Repeat Question 3 in relation to father *

5. Now I wonder if you could tell me which parent did you feel the closest to and why? Why do you think this feeling wasn't there with the other parent?

6. When you were upset emotionally as a child, what would you do ?

And hurt physically?

And were you ever ill ?

Prompts (if necessary/relevant):

How did your parents respond at these times?

Do you remember being held by either of your parents at these times?

7. What is the first time you remember being separated from your mother or father when you were little?

Prompts (if necessary/relevant):

How did you respond? How did your parents respond?

Any other important separations you remember?

8. Did you ever feel rejected as a young child? Of course, looking back on it now you may realise that it wasn't really rejection, but what I'm trying to ask about here is whether you remember ever having *felt* rejected in childhood?

Prompts (if necessary/relevant):

How old were you?

What did you do?

Do you think your parent realised how you felt?

9. Were you ever frightened or worried as a younger child (5-12)?

10. Were your parents ever threatening with you in any way, perhaps for discipline or even as a joke?

Prompts (if necessary/relevant):

Can you think of a particular time?

How old were you?

What did you do?

Do you think your parent realised how you felt?

Some people say, for example, that their parents would threaten to leave them or send them away from home..Did anything like that happen to you?

Some people say that their parents would use the silent treatment – did this ever happen with your parents?

11. Some people have memories of threats or some kind of behaviour that was abusive. Did anything like this ever happen to you, or in your family?

If 'Yes':

How old were you?

Did it happen frequently?

Do you think your parent realised how you felt?

Do you feel this experience affects you now?

Anything like this with anyone outside your family? (repeat prompts as above)

12. In general, how do you feel your experiences with your parents as a younger child have affected your personality now?

13. Is there anything in your early experience that you feel was a setback or had a negative affect on you?

14. Why do you think your parents behaved as they did during your childhood?

15. Were there any other adults whom you were close to, like parents, as a child? ...Or any adults who were especially important to you, even though not parental?

16. Did you experience the loss of a parent or close loved one while you were a young child – for example, a close family member?

Prompts (if necessary/relevant):

What happened? How old were you?

Do you remember how you responded at the time?

Was the death sudden or expected?

Did you go to the funeral?

Have your feelings about this death changed much over time?

Have you lost anyone else close to you more recently?

17. Other than difficult experiences you may already have told me about, have you had any other experiences which felt potentially traumatic to you?

Prompts (if necessary/relevant):

Anything overwhelmingly and immediately terrifying?

18. Now we'll think a bit more about your life more recently, say between 12 and now.

Have there been many changes in your relationship with your parents during that time?

And friends?

And romantic relationships?

Anyone else who was/is important to you from the age of 12 who we've not talked about?

19. And what about your relationship with your parents right now...what's that like?

What are the things you're most satisfied with and least satisfied with in your relationship with them?

20. Is there any particular thing which you feel you learned above all from your own childhood experiences? I'm thinking here of something you feel you might have gained from the kind of childhood that you had.

21. We've been focusing a lot on the past in this interview, but I'd like to end up looking quite a way into the future. We've just talked about what you think you may have learned from your own childhood experiences. I'd like to end up by asking you to imagine that in the future, you have a little girl of your own. What sort of parent do you imagine you would be to her and what do you hope she might learn from her experiences of being parented by you?

Prompts (if relevant/necessary):

How do you think you would feel if you had to separate from your child?

Do you think you would ever be worried about your child?

If you had three wishes for your imagined child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your child.

END.

* If not applicable, e.g. in case that parent died before adolescent was born, or they never knew them, then questions will be asked in relation to their defined mother/father figure.

APPENDIX 11:

Extract from the Reflective Functioning Manual (Fonagy et al., 1997) showing RF codings

June 1997

REFLECTIVE-FUNCTIONING MANUAL

Version 4.1

FOR APPLICATION TO ADULT ATTACHMENT INTERVIEWS

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Passages in response to these demand questions must be rated, and should later be taken into account when arriving at a global rating of the interview. In some interviews, interviewers might use prompts which in effect are demand questions (eg 'And why do you think they did that?') and passages which follow such prompts should be treated in the same way as passages following the questions listed above. If the speaker has already addressed a demand question in their response to a previous question, no penalty is incurred. Non-reflective responses to permit questions, i.e. all other questions, should not carry as much weight as they would if provided in response to a demand question. When combining the scores, highly rated responses to these other questions should contribute to the overall rating.

6.2 Guidelines for rating identified passages:

Six scale points are defined below. Based on reviewing the definitions of RF given above in sections 3,4, and 5, raters should assign a score to all responses to demand questions, as well as any other responses that merit attention. Some effort should be given to assigning a typology to each low rating in order to facilitate final classification.

-1 or Negative RF

Passages which are rated as negative or '0' must be distinctly anti-reflective or bizarre/inappropriate and must occur in response to a demand question.

An anti-reflective passage expresses hostility or active evasion in response to a demand for reflection. In this context, hostility is seen as an explicit expression of displeasure in relation to mentalising. Active evasion is the avoidance of such displeasure by engaging in incompatible activities. Sometimes the subject may express overt hostility by criticising the interviewer or the task. More commonly, however, active evasion consists of trying to distract the interviewer from the task by, for example, starting a conversation on an irrelevant topic or disengaging from the task by engaging in any activity which precludes complying with the demands of the task. Sometimes these reactions are non-verbal, for example: getting up to make a telephone call or going totally silent.

Bizarre explanations of behaviour unequivocally invoke mental states in self or other which are beyond the bounds of common-sense psychology or even poorly-applied theory-driven insight. To be rated negative the passage must be impossible to understand without making the assumption of 'irrationality' on the part of the interviewee. Bizarreness usually arises contextually, in other words in relation to other statements which the subject has made. Sometimes statements are less bizarre and more 'inappropriate' in the context of the interview situation as a whole. Complete non-sequiturs, over-familiarity, gross assumptions about the interviewer on the part of the subject are examples. These are also contextually bizarre except the context in this case is the interview situation as a whole rather than a specific part of the interview.

1 Absent but not repudiated RF

This rating also applies uniquely to passages in response to demand questions. In general this rating would be given when the passage contains no evidence of: a) awareness of the nature of mental states, b) an explicit effort to tease out mental states underlying behaviour, c) a recognition of the developmental aspects of mental states or d) interaction with the interviewer indicative of the awareness of the mental states of that person.

Most commonly, responses in this category are indicative of the subject being adept at sidestepping questions referring to their own feelings or the mental states of their caregiver. Passages rated as 1 may be sociological, excessively generalised, concrete or overwhelmingly egocentric. Passages can only be rated as 1 if the rater is no better off in terms of knowledge of the mental state of subject, caregiver or other having read the passage than he/she was before reading it. Even if the rater suspects the accuracy of the subject's representation of mental states, this would be insufficient grounds for rating the passage as 1 unless the passage is grossly self-serving. Thus it is not sufficient to be inaccurate to get a '1' rating, the passage has to be inaccurate in the direction of self-aggrandising, ego-centric and indicate that the interviewee is quite out of touch with the mental states of those around him/her.

3 Questionable or low RF

This rating is given to the quite common passages where the rater is uncertain if the passage represents genuine reflective-functioning or just a 'canned' statement which is repeated in response to the interviewer's demand but is not underpinned by genuine reflective-functioning. The passage may make use of mental state language but there is an absence of material which would support the assumption that the subject genuinely understood the implications of their statement. This is a borderline category. The rater should focus on whether the statement is 'obvious' and could be said simply as a 'manner of speaking'. If a statement is counter-intuitive in that context even though it is 'canned' a higher rating may be appropriate.

Most frequently '3' statements are somewhat banal and superficial. The reflective-functioning may be there by suggestion but it is unclear and is as likely to be a cliche as a proper reflective statement. Most of the statements could be seen as reflective if the rater was to regularly give the subject the 'benefit of the doubt'. Also, statements which are definitely mentalising but excessive and irrelevant to the task are commonly given a 3 rating. These statements are considered to be on the borderline because although they are psychologically minded they do not carry conviction. Thus again the rater is uncertain if the statement should be credited or not.

If the phrase appears to fit the descriptions for moderate-to-high RF statements given in section 3 of the Manual, a score of 3 would be inappropriate. The rater should have a reason why a statement of that sort cannot be confidently assigned a higher rating. Other than the 'canned' nature of the reply, common reasons might be strong prompting from the interviewer, a failure to be fully explicit, and the rater's uncertainty if he is not attributing mental state reasoning to the subject on the basis of his/her own construal of the utterance.

5 Definite or ordinary RF

Passages rated 5 must have a feature which makes reflection explicit. This is the most important criterion. If there is no explicit reference to either the nature of mental states, how mental states relate to behaviour, the properties of mental states or mental states in relation to the interviewer, then the rater should consider assigning a lower mark to the passage. Even if the mental state is fairly simple, if it is described clearly and in a way which does not suggest a restatement of what might be socially expected, this rating may be appropriate

Other than being explicit, the statement does not need to reflect sophistication. Although the statement should not be a cliche, it may be fairly ordinary, not reflecting particular insights or sensitivities. Normally the passage fits fairly well under one of the categories listed under the examples given in section 3 above. If the passage contains indication of a number of the features listed in that part of the manual, the rater should consider giving the passage a higher rating. One of the six reasons, below, for rating 7 may be present in the context of a very simple observation of mental states which would otherwise rate only a 3; in these cases, a 5 is likely to be appropriate.

7 Marked RF

Passages rated '7' are usually broader than those rated '5' but essentially they meet similar criteria. These passages are rated higher for one of 6 reasons.

1)The passage may contain a sophisticated statement concerning mental states which fits the description of at least two of the categories listed above. Here the rater is looking for passages readily classifiable as being reflective. The statement owes its 'obviously' reflective nature to combining several features of mentalising such as clear awareness that mental states, rather than physical or social forces motivate behaviour in self and other as well as indicating a recognition that individual perspectives on the same objective event may differ.

(2) The passage may be 'marked' in reflective-functioning because the view of mental states presented by the subject is unusual and surprising to the rater. Passages which cast an original perspective, which nevertheless is readily understandable to the rater, reflect mentalization on the part of the subject. Rater's should however be aware of the possibility of "borrowed" reflective-functioning, where the subject is repeating ideas presented to him/her in other contexts (family legends, therapeutic consultations, etc.). In such instances a rating of '3' would be far more appropriate.

(3) The passage may be complex or elaborate in that the mental state of the self or the other is described in unusual detail. Rater's should look out for the presentation of complex, multi-layered mental states, conflicts, mixed emotions, false beliefs and the like. It is important that for a rating of '7' the passage should indicate that the multiple mental states attributed to the person are considered alongside one-an-other and in relation to one an other.

(4) A rating of '7' should be given to passages where mental states are placed within a causal sequence. By this we mean that the subject considers (a) how the mental states arose (what perceptions of reality lead to the belief or desire assumed), (b) how the mental state influenced behaviour and © what impact or implication the mental state has subsequent perceptions, beliefs and desires.

(5) A somewhat overlapping but occasionally separate reason why a "marked" rating is appropriate rests in the interactional perspective on mental states manifested by some subjects. Interactions refer to seeing mental states as impacting on one an other in a causal way. Such interactions may be of two kinds. (a) More commonly subjects explicitly state how the mental state of one person may impact on the mental state of another. This may be in the context of the feelings of one effecting the feeling state of another or how perceptions of the expression of feeling in one person is construed by another or how experiences of certain circumstances are interpreted by one person differently from another and how these different perceptions effect respective behaviours etc. (b) Less frequently subjects may consider the interactions of mental states within a single mind. Here the common examples involve conflicting perceptions or desires and mixed emotions and the subject explicitly elaborates how these are reconciled by a metacognitive process. If the latter mental actions are described in full the rater should consider awarding a higher rating to the passage ('9').

(6) If a subject acknowledges a particularly painful situation, with the thoughts or feelings appropriate to that, then credit is given for the subject's willingness to accept experiences rather than defend against them, rationalise the behaviour of people who hurt him or her, etc..

Illustration: Interviewer: "were either of your parents ever threatening to you in any way, either for discipline or jokingly?" Subject: "My father was threatening to me once... I was being a pain, I wouldn't do something, my mum and I had an argument about it. She was very upset and I was being stupid. I wouldn't acknowledge that I was upsetting her so much. My Dad found me and came and shook me, and told me how much I had hurt my mother. He was quite rough and I was really scared. He came back later and said he was sorry and explained, and we made it up. Interviewer: "What did you feel about that?" Subject: "I can remember thinking "Ah, I've got him! ... I shouldn't have felt it really, but there was a feeling of triumph."

9 Full or Exceptional RF

The difference between this rating and the previous rating is as much one of degree or quantity as of quality. The same reasons which may lead a rater to assign a "marked" rating may lead him/her to consider awarding an "exceptional" score. The difference lies in the amount of sophistication shown, the degree of complexity presented, the completeness of the causal account, the degree of 'surprise' the rater experiences at the subject's understanding, the intricacy of the interaction between mental states offered etc. For a rating of '9' the passage must be relatively unusual in these regards.

A further circumstance which might justify the award this rating even to passages which

would normally be rated "marked" is the context in which the passage appears. If the rater sees the part of the narrative as particularly emotionally charged and difficult for the subject then showing even ordinary levels of mental state understanding may be considered "exceptional". Examples might include the understanding or rejection, neglect or abuse by the caregiver in childhood, or understanding feelings of current anger or resentment toward the attachment figure in oneself. The rater should note that the presence of mentalising may give the 'impression' that the experience recounted was not exceptionally difficult. To circumvent this the rater should take an "objective" (almost sociological) view of the difficulty involved in the experience for that person and adjust ratings accordingly. For example rejection by one parent may not be quite so difficult for someone who appears to be assured of the love and commitment of the other parental figure. By contrast, an individual whose history reveals no such ameliorating factor might be more readily credited with an "exceptional" rating if the understanding they show is of the experience of rejection meets the criteria for "marked" reflective function.

The most common justification for an "exceptional" rating is the apparent full awareness of the subject of important aspects of the mental states of all protagonists within an interaction, where the protagonists are placed in relation to one an other in terms of their feelings and beliefs and these are sufficiently complex and elaborate for the rater to be convinced of their accuracy. The subject offering such a "full" picture may not be exceptionally insightful, although the passage must contain sufficient "surprise" for the rater to feel it is unlikely to have come from contaminating sources (e.g. regurgitation of the therapist's view). The passage should have sufficient personal character for the rater to feel confident that the understanding was developed by the person either in the process of the interview or prior to it yet it is still experienced as personally significant and meaningful.

In an ordinary sample we would not expect more than 10% of scored passages to receive this high a rating across interviews.

6.3 Rules for aggregating reflective-functioning ratings into a single score for each Adult Attachment Interview

Although each identified passage of the interview, particularly the responses to demand questions, is scored by raters, the almost infinite number of permutations which may end up characterising an interview means that there is no simple formula for arriving at a global rating. Rather, the rater has to consider the interview as a whole. However, it is not suggested that the rater should take an arithmetic average of the ratings given to core passages or even to all passages in the transcript. The psychometric properties of the individual ratings simply do not permit this simple expedient. The rater has to come to a judgement about the whole text on the bases of this manual and in relation to their experience of other narratives to which they have assigned ratings.

It is desirable that the rater should be able to justify why they gave a particular rating. This can be done in a brief RF report which indicates how they arrived at their judgement and the decisions they followed. Such reports need be no longer than perhaps one or two paragraphs highlighting the central themes or speech examples they used in arriving at a

judgement. In all cases the particular rating rule they followed should be clearly indicated.

Although some simple rules for allocating the interview into one or other of these complex categories are available, none of these should be used blindly and they should not override the rater's impression of the entire interview. For example an interview may contain striking examples of negative RF at the same time as containing one or two examples of marked RF. In such a case, none of the formulae offered for assignment of a global rating apply and the rater has to decide if the best fitting category is 1 or 3. In making such a decision the interview would have to be looked at as a whole and the rater will have to make a judgment if RF may be considered to be absent in an attachment context (1) or is relatively low and patchy (3).

In making higher ratings the rater should also consider the total interview. For example, quite commonly a particular passage in the interview may not merit a '5' rating, but when considered in the context of the whole narrative the same text may clearly merit a higher rating. Sometimes the rater may not be able to decide between adjacent categories. For this reason, classifications are anchored at odd numbers. When the rater is confident that a particular transcript falls in between two classes, he/she should consider to assign the even number in between the classes to the transcript.

6.4 The overall interview rating

-1 Negative RF

This overall rating should only be given to interviews, very rare in normal samples, where the interviewee systematically resists taking a reflective stance throughout the interview. The subject is either hostile to the notion of reflection expressed in derogation and dismissal of any attempts on the part of the interviewer to initiate such reflection or is so confused about their attempts at reflection that the rater may be said to be almost "shocked" by the utterances. In either case, for a rating below '1' to be given, the rater should be certain that not even a single scorable reflective item can be marked in the interview ('5' or above). In interviews where either a rejecting or a bizarre stance is observed alongside some ratable RF passages, ratings between '1' and '3' should be considered depending on the balance of items found.

Common Types

-1(A): **Rejection of RF**
Interviews of this type rated '-1', respond with hostile refusal to at least 3 core RF questions. In addition, there are some general characteristics of the interview such as a lack of participation in the interview process, overt hostility to the interviewer, evasiveness and marked incongruences. If the interview fits the latter descriptors but has less than three but at leat one striking hostile refusal, and no clear instance of RF is found, the interview should be rated '0'.

-1(B): **Unintegrated. Bizarre or Inappropriate**
This is a rare category and a literally puzzling one for the rater. Its hailmark is that mental

state attributions are hard to understand. To place an interview in this category the interview should contain at least three examples where an inexplicable, bizarre or inappropriate attribution was made by the subject. These need not occur uniquely in response to core RF questions. It is, however, insufficient for the answer to be unusual or simply odd. The rater's reaction is likely to be one of shock that anybody could make such an attribution in such a context. As an extreme example, frankly paranoid responses or thought disordered ones would create this kind of subjective reaction. In addition there are some general features of such interviews including a lack of meaning, a lack of explanation, a comprehensive avoidance. If the rater identifies at least 3 instances of bizarre explanations of behaviour either paranoid or thought disordered or highly incoherent and therefore impossible to understand but not thought disordered. If the interview is generally poorly integrated or somewhat bizarre in terms of mental state attributions but there are less than three clear passages of this type and no passages are rated '5' or above, the interview should be assigned '0'.

1 Lacking in RF

This rating should be given to interviews where the reflective-functioning is totally or almost totally absent. The interviewee may adopt a range of strategies to prevent the task of reflection. In these interviews there may be a number of instances of mental states being mentioned with regard to the self or other, but these never lead to a coherent picture of the subjects or the caregiver's beliefs and feelings underlying behaviour. To the extent that mentalizing statements are present, these are simplistic and banal and cannot be differentiated from statements that another subject might make on the basis of completely different experiences. Alternatively, reflective statements are so clearly inaccurate and full of misunderstanding and contradiction that the rater can confidently conclude that the statement is not based on genuine reflection. In all cases, mentalisation is absent in the narrative and awareness of the nature of mental states, if present, is only discernable by inference.

Common Types

1(A) **Disavowal**

There are at least 3 instances in the transcript of assertion of ignorance concerning mental states. Alternatively, there are comparable examples in these core passages of evasion of questions, physicalistic, behavioural or sociological accounts and global and generalised statements concerning the psychological state of the other or the self. In general terms, such accounts tend to be barren, lacking in mentalizing detail and mentalizing phrases are restricted to those in use in 'common parlance' (canned explanations). A certain concreteness tends also to characterise such interviews. In order to assign this category there can be no instance of reflective function rated above 3.

1(B) **Distorting/self-serving**

These interviews do contain reflection but are seen by the rater as flawed. Principally reflective passages and answers to core questions are egocentric, exaggerate the importance of the narrator, are overly favourable to the subject or are self-serving to the point where the accuracy of the representation of the mental state of the other may be

justifiably or reasonably called into question. A key bias to the depiction of mental states is social desirability – subject wishes to present himself in a favourable light. These distortions can lead to marked inconsistencies in the presentation of the mental world of both self and other. Subjectively, the rater is most likely to feel a strong sense of irritation with such interviews. To use this category the rater should note at least 3 instances in the transcript of such purposeful distortions in response to core RF questions. Further there should be no instance of reflective function rated above 3.

3 Questionable or Low RF

This rating is given to transcripts which contain some evidence of consideration of mental states throughout the interview albeit at a fairly rudimentary level. Interviews receiving a 3 will contain elements of a reflective stance, for example the interviewee may consider developmental or intergenerational elements which are not seen by the rater as banal (i.e. a lower rating) but are nevertheless not specific enough to the individual's personal experience to merit a higher rating. An interview rated a 3 may contain more than one example of reflective-functioning at level 5 or above. Further, it must contain at least 3 instances of a 3 rating. In reading many of these transcripts the rater may intuitively wish to attribute to the interviewee a relatively good capacity to reflect but, in the absence of concrete evidence for this in terms of at least 3 ratings at '5' or above, this may be indicative of the rater's rather than the interviewees capacity. For the most part, references to mental states and their impact on behaviour are not made explicit. Also, a number of relatively reflective passages may be counterbalanced by negative ratings elsewhere (although not of sufficient frequency to warrant that rating). However, if the rater, through taking the interview as a whole, is readily able to bring together aspects of the interview which would clarify the mentalising content of such a passage, a higher rating should be given.

Common types

3 (A) **Naive-simplistic**

These transcripts show a partial appreciation of intentions of others either within instances or across transcript as a whole. The understanding offered may be very superficial, often totally banal, with excessive use of cliches in referring to mental states and perhaps normalisation of negative experiences beyond what may be culturally accepted. The understanding is rarely specific to personal experience, either of self or other, does not enter into the complexities of mental states (conflict, ambivalence etc) . The interview is likely to contain many 'canned' statements and the interviewer is likely to experience a sense of superficiality about such transcripts. To assign this category the rater is expected to have identified naive simplistic passages as the majority of low ratings and fewer than 3 ratings of 'marked' RF.

3 (B) **Over-analytical or hyperactive RF**

This is an important but somewhat difficult category. To the naive rater such transcripts may seem quite reflective. In fact one of the hallmarks of the category is that the interview has somewhat greater depth than might be expected in the context of such an interview. The interview is diffuse, however, and the insights offered are unintegrated and do not link

5/A **Ordinary understanding**

The subject shows a capacity to make sense of their experience in terms of thoughts and feelings, and has a consistent model for this which needs little or no inference from the rater. However, the model is limited, and would not tackle the more complex aspects of interpersonal relationships, e.g. conflict or ambivalence, which are not necessarily well understood. The transcripts need to have at least 3 instances warranting a 5 rating, and no breakthroughs of rejection or bizarre explanations, pervasive disavowal, etc..

5/B **Inconsistent level of understanding**

The subject appears to be achieving a higher level of understanding in some parts of the interview, so that certain passages may achieve scores of 6-7. However, the understanding cannot be maintained in relation to more problematic areas of the subject's interview, such as a conflictual relationship with one parent. These parts of the interview would nevertheless not be expected to fall below a rating of 1-2.

7 **Marked RF**

These interviews have numerous statements indicating full reflective function which evidence awareness of the nature of mental states and explicit attempt at teasing out mental states underlying behaviour. Normally, awareness of mental states is clear throughout the interview with frequent passages where the speaker has arrived at an original reintegration of the states of minds of those around them or their own state of mind which the rater finds surprising in the sense of not having thought of it himself or herself. There is also much detail about the thoughts and feelings of all the protagonists and the implications of mental states are regularly spelt out. The person is usually also able to maintain a developmental (intergenerational) perspective. As a whole, the interview gives the rater the feeling that the speaker has a stable psychological model of the mind of his caregivers and his/her own reactions to their mental states.

Any single passage may only illustrate one of the features of full reflective function listed above, but the interview as a whole gives the impression of someone who is applying a reflective stance fairly consistently to at least one context in their life, e.g. relationship with mother, or less consistently to a number of contexts. Across the interview, one would expect a number of different types of examples of reflective-function but the reader can identify limitations in terms type or application to context. In order to assign a global rating of '7' the rater should identify at least 3 passages which may be given this rating or higher anywhere in the interview, no passages which obtain a rating of '1' or lower and no more than 3 passages where the rating is less than a '5' in response to core questions..

9 **Exceptional RF**

These transcripts are rare. These transcripts show exceptional sophistication, are commonly surprising, are quite complex or elaborate and consistently manifest reasoning in a causal way using mental states. A 9 rating would be given to transcripts which show a consistent reflective stance across all important contexts. A 9 rating for a single passage is given where several aspects of reflective function are integrated into a unified, free perspective. Where 3 such passages are noted in any single interview, the rater should

assign a 9 rating to the interview as a whole. Across the interview, many aspects of full spontaneous reflective function would be shown in the discussion of different relationships at different times in the speaker's life history. It is unlikely that such an interview would have many passages rated '3' and most would be rated '5' or '7'. If the transcript does not meet the criteria above, yet the rater 'feels' the transcript to be exceptional a rating of '8' should be considered. If only a single '9' rating is present and/or there are more than a couple of examples of questionable RF a rating of '8' is likely to be too high and '7' should be considered.

Acknowledgements

We are grateful to Abby Shachter for help in preparing the previous version (3.3) of this manual. We are also grateful to Arietta Slade who carefully read, commented upon and helped prepare this version of the manual.

APPENDIX 12:

Ethics and Research and Development Committee approval letters

HEALTH AUTHORITY

30th September 1999

Rachel Thomas
Psychologist in Clinical Training

Tel
Fax
Minicom

Dear Ms Thomas

Perceptions of Attachment and Family Functioning in Adolescent Girls with Eating Disorders and Depression and Their Families

Our Protocol No. (Please quote in all correspondence)

At the meeting on Wednesday 15th September 1999 the Local Research Ethics Committee reviewed your updated patient information sheet and answers to their two questions. Thank you for responding so promptly to the Committee's requests. The work was amended to the Committee's satisfaction.

The members of the Committee present agreed that there is no objection on ethical grounds to the proposed study whose title is given at the head of this letter. I am therefore happy to give you our approval on the understanding that you will follow the protocol as agreed.

The project must be started within 12 months from the date of this letter. It is your responsibility as the researcher who made the application to notify the Local Research Ethics Committee immediately you become aware of any information which could cast doubt upon the conduct, safety or an unintended outcome of the study for which approval was given.

If there are amendments which, in your opinion or opinion of your colleagues, could alter radically the nature of the study for which approval was originally given, a revised protocol should be submitted to the Committee.

You will no doubt realise that whilst the Committee has given approval for the study on ethical grounds, it is still necessary for you to obtain approval from the relevant Clinical Directors and/or Chief Executive of the Trust in which the work will be done.

Members of the Committee would like to know the outcome of the study and therefore ask that a report or copy of results is sent to the Secretary in due course.

Yours sincerely,

Dr.
Chairman - Local Research Ethics Committee

cc: , Chief Executive, Healthcare Trust

TELEPHONE

Ms Rachel Thomas

15th October 1999

Dear Ms Thomas,

Re: Proposal - Attachment and family functioning in adolescent girls with eating disorders and families

This proposal has been provisionally approved. Before it can be formally approved, you would need to make a change to the wording in the Information Sheet. Under the heading 'What about Confidentiality' you have used the words 'unless you express the wish to hurt yourself or someone else'. It would be helpful if you could change this phrase to 'unless you are in danger of hurting yourself or someone else'.

Could you send me back an amended information sheet?

Thank you for your help.

Yours sincerely,

Secretary to Research Ethics Committee

c.c.

Telephone:

Fax:

Ms Rachel Thomas

10th November 1999

Dear Ms Thomas,

Re: Proposal: Attachment and family functioning in adolescent girls with eating disorders and their families - Rachel Thomas

I am pleased to inform you that the above proposal has now received formal ethical approval.

Yours sincerely,

Secretary to Research Ethics Committee

Telephone: Fax:

TELEPHONE

4th October 1999

Ms R. Thomas.

Re. ***Perceptions of attachment and family functioning in adolescent girls with eating disorders or depression and their families***

Dear Ms Thomas,

Thanks very much for your thorough letter and updated protocol. I was very impressed by the calmly constructive way you seem to be handling all these, necessarily very bureaucratic, hurdles. I gather that your application is with the ethics committee and, as you'll see from the note overleaf, this time I am confirming more clearly that I give permission on behalf of the research committee for this project to go ahead.

As a piece of purely informal advice looking toward your eventual dissertation, I'd make it very clear you understand just how little statistical power a study of three groups of ten each has to detect differences. In many ways you are likely to be looking at pairwise comparisons of groups. Say the population difference on the PBI between the two clinical groups is small, an effect size of .2, then you have a power of 7% for alpha of .05, two-tailed. Even with a large effect size of 1 the power is only 56%. I know you do understand this but it's the sort of thing you'll really have to defend!

One formal request. As I said in my last, rather unclear message:

> Please would you let me know through internal post or Email (chris@psyctc.org) the final protocol, the clinical groups that are involved (T-P and external) and the course involved (presumably Clin. D. Psych. from the Solomons) and progress of the project. (I.e. ethics committee approval, recruitment started, finished, dissertation completed, result, any publications resulting or spin-off studies).

Email is much the preferred route: a copy of the final protocol in Word or RTF format would save me lots of tedious typing and clarification of the other details and progress would be much appreciated: I'm trying to keep track of these things. Come back to me if you find you need help with things administrative, strategic or psychometric though I'm sure you have sufficient support from Dr. Leiper

Now an informal request: you mentioned the two new measures: the S-I.T.A. and the Y.S.R. The copies didn't reach me which doesn't concern me in relation to the application but if you can spare a copy of each then I'd be very interested to get them as I'd like to build up a referential pack of measures that have been used in T&P research. The PBI, FACES & BDI are ones I know but those were new to me. On a related

measure: make sure you satisfy copyright requirements for any measures. As ever, depressingly, this is something the Trust has to make clear to people!

Finally, you may wish to know that yours is the first submission to go through the reseach committee's new, evolving fast-track process for course student projects. We'll be bringing the submission process for the ethics and research committees together and I'll probably end up on both committees. That should make things easier for future applicants even though, of course, the remits of the two commitees must remain distinct. Anyway, I've learned from this first run through: thanks!

4th October 1999

cc.

TELEPHONE
FAX

NHS TRUST

CHAIRMAN

CHIEF EXECUTIVE

REPLY TO EXTENSION

31 March 2000

Ms Rachel Thomas

Dear Ms Thomas

Re:

PERCEPTIONS OF ATTACHMENT IN ADOLESCENT GIRLS WITH EATING DISORDERS AND CLINICAL DEPRESSION

This is to inform you that the queries raised on the above application have been satisfactorily answered and your submission is therefore approved. A formal letter of approval will be sent out after the next committee meeting.

Please note that ethical committee approval does not mean that the study may commence. The study may only commence following approval by the Trust through the office of the Director of Research & Development (if you have any queries please contact on extn.).

Yours sincerely

Secretary

Local Research Ethics Committee

NHS TRUST

CLINICAL INFORMATION CENTRE

NHS Trust

Switchboard. Fax.
Direct line. e mail:

05/04/2000

Dear Ms. Thomas

Re: Perceptions of attachment in adolescent girls with eating disorders and clinical depression

R&D ID.

Following the approval of your ethics application your project has been fully registered with the R&D department. I would be grateful if you would inform me of any changes regarding funding, project status e.t.c

Should you have any queries please quote the ID number.

You may proceed with your project.

Sincerely,

Research & Development Officer
Clinical Information Centre

APPENDIX 13

Strategic Director Education & Libraries
County Pupil Services Officer

County Council
EDUCATION & LIBRARIES

Rachel Thomas

Direct Dial/Ext:
E-mail:
Minicom:
Ask for:
Your ref:
Our ref:
Date: 27th August 1999

Dear Rachel

RE: STUDY INTO ADOLESCENT GRILS' (AGED 13-18) AND THEIR PARENTS PERCEPTIONS OF THEIR FAMILY RELATIONSHIPS

Thank you for your letter dated 18th August. I would be happy for you to contact local headteachers in order to request the participation of their schools in your study, and you have my permission to do so.

I wish you every success with your study.

Best of luck.

Yours sincerely

pp

Head of Psychology Service

APPENDIX 14:

PARTICIPANT INFORMATION SHEETS

A RESEARCH STUDY: ADOLESCENTS' AND PARENTS' PERCEPTIONS OF FAMILY RELATIONSHIPS - INFORMATION SHEET FOR PARTICIPANTS

You are being invited to take part in a research study. Before you decide whether or not you want to take part, it is important for you to understand why the research is being done and what is involved. Please take some time to read the following information carefully and to discuss it with family, friends and your GP if you want to.

1. About the study

The study looks at the family, life and relationship experiences of young women (under 21) referred to mental health services. I am interested in hearing from young women who would be willing to discuss their experiences with me in confidence and am approaching young women currently receiving treatment in clinics across the South East. I am independent of the clinic at which you are receiving/have received treatment and your decision to take part (or not) in this study will in no way affect your treatment there.

2. What will be involved?

There will be two parts to the study: in one part, I will ask you to complete some confidential questionnaires at home about your current mood, behaviour, your family life, relationships and current difficulties. I will send you full instructions with the questionnaires about how to complete them. The questionnaires ask about your thoughts and feelings. They are not a test and there are no right or wrong answers.

In the other part, I will interview a smaller number of participants (with a maximum number of 2 per clinic) in more depth about experiences of growing up in your family and how you feel these experiences have affected you. This will take between an hour and an hour and a half and where possible will be at the clinic where you are currently being seen/have been seen.

I aim to be as sensitive to your needs as possible and you will be able to ask for a break at any time. I will ask you at the end of the interview for some brief feedback on how you found the interview and questionnaires. If for any reason you feel upset after taking part in the research and want to talk to someone, then I am available to be contacted by phone and can see people for a follow-up meeting if they wish. If applicable, I can also make sure that your named mental health worker is informed that you are upset and/or that additional support can be provided if you need it.

3. Do I have to take part?

It is up to you whether you decide to take part. If you do decide to take part, you will be given a copy of this information sheet to keep and be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any time without giving a reason. This will not affect the standard of care you receive.

4.What about confidentiality?

Your answers will be kept completely confidential (unless you are in danger of hurting yourself or someone else, in which case your GP will be informed). Your responses to questionnaires will only be seen by me unless you would like them shared with anyone else (e.g. a therapist who is working with you). You need not put your full name on questionnaires if you prefer not to.

All interviews will take place in a private room. I will tape record interviews to remind me what people have said, but no one will listen to the tapes apart from myself and perhaps one or two professional colleagues from the Salomons Centre in Kent, with whom I may need to consult about the research. They will also maintain the strictest confidentiality. Tapes will be

destroyed as soon as I have finished and written up the research. When I write up my research, no names or other identifying details will be mentioned. I will let your GP know that you have taken part in the study only if you agree to this.

5. What will you gain from it?

I hope that participating will give you an opportunity to talk and think about your difficulties in a confidential, independent setting that will not affect your treatment in any way. I also intend that my findings will ultimately be read by other mental health workers helping young women with experience of psychological distress and their families and your views and experiences will therefore have the opportunity to influence how other young women and their families are helped in the future. The study may be published next year: no identifying details of any individual or family taking part will be mentioned in this event.

6. Parents

If you are in agreement, I would like to ask your parent(s)/carer(s) to complete some questionnaires also. I will not need to interview them. There is a section on the application form to say whether it will just be you or you and your parent(s) who will participate. This is up to you. You may want your parents to be involved, or you may prefer just to take part on your own. **Either is fine.**

Please note that all answers given to me by parents and daughters will be kept confidential from one another, whatever you decide. If you would like your parent(s) to be involved, then they also need to sign the application form to indicate that they are willing to take part and have also read the information sheet.

Even if you decide that you would prefer your parent(s) not to be involved, if you are under 16, you still need to ask one of your parents to sign the form agreeing for **you** to take part in the study. This does not apply if you are 16 or over.

7. If you are interested in getting involved, what happens next?

If you are willing to participate, please complete the attached consent and application form and return it to me in the envelope provided as soon as possible together with your completed questionnaires. Full instructions on completing questionnaires are enclosed in your pack. If you think you might be interested, but feel unsure and would like to discuss anything further then **PLEASE DO** telephone me. You can leave a message on……(work no.)….. Monday-Friday with your contact telephone number and I will return your call.

Thank you for your interest in the study.

Yours sincerely,

……

Rachel Thomas,
Psychologist *
Salomons Centre

* Several clinical directors advised me that this term was preferable to "Psychologist in Clinical Training" on the grounds that the latter may make adolescents feel obliged to take part on the grounds of 'helping me with my training'.

CONTROL GROUP VERSION

A RESEARCH STUDY: ADOLESCENTS' AND PARENTS' PERCEPTIONS OF FAMILY RELATIONSHIPS - INFORMATION SHEET FOR PARTICIPANTS

You are being invited to take part in a research study. Before you decide whether or not you want to take part, it is important for you to understand why the research is being done and what is involved. Please take some time to read the following information carefully and to discuss it with family, friends and your GP if you want to.

1. About the study

I am a Psychologist doing some research into the life and relationship experiences of young women and those of their families. I am interested in hearing from young women up to the age of 21 and their parents who would be willing to tell me about their experiences in confidence.

2. What will be involved?

I will be asking you to complete some confidential questionnaires about your current mood, behaviour, your family life and perceptions of your relationships. I will send these to you by post to complete. I will give you full instructions with the questionnaires about how to complete them and you will be able to telephone me if you have any queries about them. If I will not be seeing you for interview, I will also phone you, with your permission, within a week of receiving your completed questionnaires to ask how you found them. It will be very important that you complete the questionnaires on your own and not jointly with anyone else. If your parents are also taking part and completing questionnaires (see item 6.) then it is important that you don't compare answers or show each other your completed questionnaires. The questionnaires ask about your thoughts and feelings. There are no right or wrong answers. They are not a test.

I may also, with your consent, interview you in more depth about your experiences of growing up in your family. Agreeing to be interviewed will involve meeting with me individually for approximately 1½ hours. Where possible, this will be at your school, otherwise at a nearby family centre. I aim to be as sensitive to your needs as possible and you will be able to ask for a break at any time. I will ask you at the end for some brief feedback on how you found the interview. If a large number of girls want to be interviewed, I will select interviewees at random.

3. What about confidentiality?

All your answers will be kept confidential. Your questionnaire answers will only be seen by me, unless you would like them shared with anyone (e.g. your G.P. or a teacher at school). You need not put your full name on questionnaires if you prefer not to. If you say anything in your questionnaires that I think you may need help with, I will discuss this with you, but will not take this further unless you wish it. The only exception to this would be if I had concerns for your safety or the safety of someone else when I would need to let your GP know.

All interviews will take place in a private room. I will tape record interviews to remind me what people have said, but no one will listen to the tapes apart from myself and perhaps one or two professional colleagues from the Salomons Centre, with whom I may need to consult about the research. They will also maintain the strictest confidentiality. Tapes will be destroyed as soon as I have finished and written
up the research. When I write up my research, no names or other identifying details will be mentioned.

4. What will you gain from it?

I hope that participating will give you an opportunity to think about your life, mood, family and relationships in a confidential, independent context. I intend that my findings will ultimately be read by other psychologists/mental health workers working with young people and their families and that your views and experiences will therefore have the opportunity to influence how young women and their families are helped in the future.

5. What will your school gain from it?

I will be feeding back my results in general terms to all schools who have taken part in my study next autumn, when the project is finished. This will hopefully be informative to schools about the experiences of young women, the issues they face and the support they may need. These results will also be available to individuals and families who have participated, together with individual questionnaire scores for those who wish to know these. Please note that no individuals will be identified in these results.

6. Parents

If you are in agreement, I would also like to ask your parent(s) to complete some questionnaires. There is a section on the application form to say whether it will just be you or you and your parent(s) who will participate. This is up to you and your family to decide. Please note that all answers given to me by parents and daughters will be kept confidential from one another. If you would like your parent(s) to be involved, then you need to check that they are willing to take part. They will need to sign the application form to indicate that they have also read the information sheet.

Even if your parents will not be participating, you need to ask one of your parents to sign the form agreeing for you to take part in the study if you are under 16. This does not apply if you are 16 or over.

7. If you are interested in getting involved, what happens next?

If you are willing to participate, please complete the attached consent and application form and return it to me in the envelope provided as soon as possible. I will then send you the questionnaires and instructions and a time and date for interview, if you have consented to this and have been selected. If you think you might be interested, but feel unsure and would like to discuss anything further then **PLEASE DO** telephone me. You can leave a message on....(work number)....Monday-Friday.

Thank you for your interest in the study.

Yours sincerely,

.....

Rachel Thomas
Psychologist
Salomons Centre

APPENDIX 15

CONFIDENTIAL

Application and Consent Form

1. Full name.....

2.Age.....

3. Contact Telephone numbers:

Day (if contactable).....

Evening.....

Do you give your consent for me to telephone you for feedback? **Yes/No** (please delete as applicable)

4. Contact address(es) (if different from that to which letter was sent)

.....

.....

5. Current GP details (name, address, phone)

.....

.....

.....

Do you give your consent for your GP to be informed that you have participated in the study? **YES/NO** (please delete as applicable)

6. Are you willing to complete some confidential questionnaires about your current mood, feelings, family life and relationships? YES/NO

7. Would you also be willing to be interviewed? YES/NO

If yes, please list any times you would not be available:

.....

.....

8. Are you willing for me to contact your parent(s)/carer(s) to complete some questionnaires (with full confidentiality of your and their responses guaranteed, as explained in the Information Sheet)?

YES/NO (please delete as applicable).

9. If YES, then parents please complete:

Full Name(s).....

.....

Address(es) and phone number(s) (*if different to daughter's)*

.....

.....

.....

9. Any other information you feel it is important for me to know?

.....

.....

.....

Please sign below if you are happy to proceed :

I (We) have read the information sheet and agree to take part in a psychological study about the life and family experiences of young women. I (We) understand that this will involve completing some questionnaires. I (We) understand that answers will be kept in the strictest confidence and that all identifying details will be anonymised when the research is written up. I (We) understand that I (We) can contact the researcher, Rachel Thomas, if I (We) have any further questions or concerns before agreeing to take part and that she will contact us (me) by phone after she receives the questionnaires, with permission, to get some feedback.

Signed (daughter):

.....

.....

(parents – if participating):

.....
.....

For young women under 16 only – parental agreement.

I agree for my daughter to take part in the above psychological study. I have read the information sheet supplied to her and am happy for her to proceed.

Signed:

.....

.....Parent(s)

APPENDIX 16:

Questionnaires: General instructions

Please could you read these general instructions before proceeding further: -

The enclosed questionnaires ask about your thoughts, feelings and experiences. There are no right or wrong answers and they are absolutely NOT a test.

Please complete them all at one sitting in a quiet room, if possible one where you will not be interrupted or disturbed. Try not to spend too long thinking about your answers, just use your 'gut' response or the one that comes into your head first. Please be as honest as you can. No one is going to be judging you for how you respond and honest answers are much more helpful.

Please complete the questionnaires in the order they are placed and write clearly and legibly using a black ink pen or biro. Please print any handwritten answers for clarity. If you make a mistake, don't worry, just draw a line through your mistake and correct clearly. There is no need to write your surname on questionnaires if you prefer not to, but please DO write you first name, age and other details such as parental occupations on the questionnaires that ask for this. PLEASE ENSURE THAT YOU COMPLETE ALL ITEMS AND DON'T MISS ANY PAGES OUT.

I will telephone you after you return the questionnaires (if you have given your consent for this) to ask how you found completing the questionnaires and to answer any queries you may have. I won't be able to give you immediate feedback on your questionnaire answers, as these take time to score and analyse, but can provide feedback later in the year for anyone who is interested. If you have any questions or problems completing the questionnaires, then please don't hesitate to ring me on..... and leave a message. I will return your call as soon as possible

I look forward to receiving your questionnaires. Very many thanks for your interest in the study.

Appendix 17: Letter to parents re: control group participation

Date

Dear (school name) student and parent(s),

I am a Psychologist based at the Salomons Centre in Tunbridge Wells. I am doing some research into adolescent girls' and their parents' perceptions of their lives and relationships. I am writing to ask whether you would be willing to take part?

The research has the full backing of the school and of...*(relevant)*.... Education Authority and is being thoroughly supervised by professional colleagues at the Salomons Centre and within ...*(relevant)*.... NHS Trust. Participation will involve filling in some questionnaires about yourselves, your mood, behaviour and close relationships and perhaps your daughter also being interviewed by me in greater depth. All answers, whether on questionnaires or in interview, will be kept strictly confidential. That will include confidentiality between answers given to me by parents and daughters. There will be an opportunity to discuss the questionnaires/interviews with me afterwards. Girls who would like to participate on their own are also welcome to do so, but will need parental agreement if under 16.

I hope that you would find taking part interesting and worthwhile personally. Your participation would, I hope, also benefit the school considerably. I will be feeding back my results in general terms to school next autumn, to help increase their understanding of the psychological needs and experiences of girls and their parents. If you think you might be interested, please could you complete the attached slip and return it to your form tutor at school as soon as possible and **NO LATER than (return date)** . This will not commit you to taking part, but will mean I can send you more detailed information about the study and an opting in form.

Thank you very much for your interest and I hope to hear from you.

Rachel Thomas,
Psychologist, Salomons Centre.

.....

Please complete, tear off and return to your form tutor on or before .....

Full name (daughter).....

Year.....

Age.....

Full names (parent(s)/guardian(s)).....

Address.....

.....

We are willing to be contacted by Rachel Thomas regarding her psychological study:

Signatures.....(parent (s) & daughter)

APPENDIX 18

Debrief procedure for interviewees

The last question on the interview schedule alters the focus from past to future . It is hoped that this helps the participant move on from reflection on their own past experience towards thinking about what they may be able to change or influence for the next generation.

Following the interview:

How are you feeling now?

What did you find the easiest thing to talk about? What was the most difficult?

Was anything upsetting for you to talk about?

Are there any particular issues you will find yourself thinking about a lot when you leave here?

(especially important if distressed) Is there someone who you can identify that you can talk to now about the interview? (researcher and participant think together about who might be a good person to approach: clinician, teacher, parent, friend or other sympathetic adult?)

(if relevant for controls) You seem to have a lot on your mind just now. Do you feel in need of any help with these issues from someone other than family/friends (If yes, discuss options with adolescent: GP consultation and/or school counselling service for school (N=1) where this was in place).

Debrief ends by reminding participant of researcher's contact details and the fact that they can contact the researcher before the end of July if they are left with any issues that they would like to discuss further. All participants are reminded about confidentiality and of the fact that they will be sent some general anonymised feedback in the autumn for those who wish (asked to indicate whether or not they would like this). Finally participants are thanked for their time and for talking about their experiences to the researcher and are asked if they have any questions for the researcher before leaving.

APPENDIX 19:

EXAMPLE OF A COMPLETED RATING SCALE FOR INTER-RATER RELIABILITY CODING OF IPA THEMES

Rating Scale for Application to IPA themes

For each of the themes identified by the researcher within each transcript, please indicate whether you agree that it is present in the transcript: 1 (Not at all), 2 (A little), 3 (Somewhat), 4 (Mostly) or 5 (Definitely) according to the following 5 -point scales. Please use a separate one of these sheets for each transcript and make sure you complete a scale for each theme identified by the researcher.

If you identify new themes that the researcher has not identified, but which you feel are important within the transcript, then please identify and provide a rating for these after you have rated each of the researcher-identified themes.

TRANSCRIPT.....Jane.....

Theme 1: (please specify).....Disruption/isolation/depression.....

1. 2. 3. (4) 5.

Not at All A Little Somewhat Mostly Definitely

Theme 2: (please specify).....Unemployment/financial problems.....

1. 2. 3. 4. (5)

Not at All A Little Somewhat Mostly Definitely

1. 2. 3. 4. 5.

Not at All A Little Somewhat Mostly Definitely

Theme 3:.....Victim of bullying.....

1. 2. 3. 4. (5)

Not at All A Little Somewhat Mostly Definitely

Theme 4:.....Unstraining (of school home jobs).....

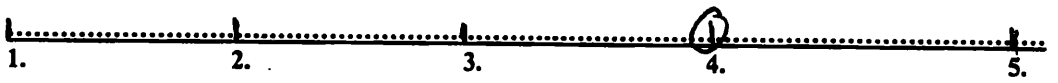
1. 2. (3) 4. 5.

Not at All A Little Somewhat Mostly Definitely

More evidence of this theme but also how different to (1)

107/125 = 85.6%
concordance on transcript

Theme 5: School / peer problems

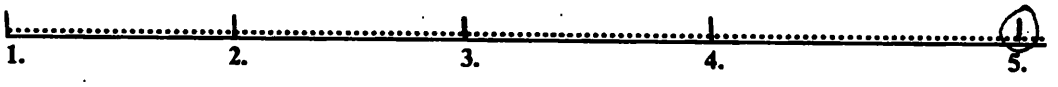


Not at All | A Little | Somewhat | Mostly | Definitely

Theme 6: Poor parental relationship / threat of parent / separa

Not at All | A Little | Somewhat | Mostly | Definitely

Theme 7: Family mental health problems

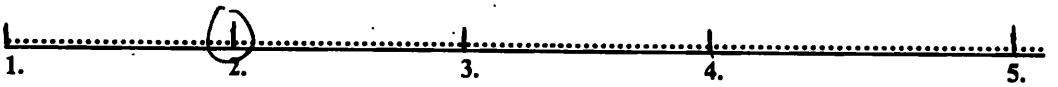


Not at All | A Little | Somewhat | Mostly | Definitely

Theme 8: Significant loss / bereavement

Not at All | A Little | Somewhat | Mostly | Definitely

Theme 9: Parental neglect / rejection

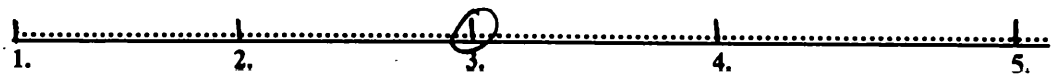


Not at All | A Little | Somewhat | Mostly | Definitely

Theme 10: Emotionally cut off / excessive generosity / isolation in society

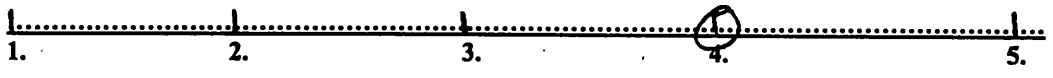
Not at All | A Little | Somewhat | Mostly | Definitely

Theme 11: anger/aggression to parent



Not at All | A Little | Somewhat | Mostly | Definitely

Theme 12: Secret keeping hurt self



Not at All | A Little | Somewhat | Mostly | Definitely

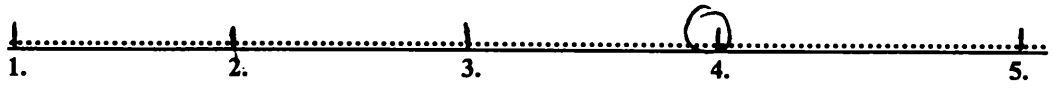
Theme 13: Depressed / suicidal feelings

Not at All | A Little | Somewhat | Mostly | Definitely

Theme 14: depression issues / environment

Not at All | A Little | Somewhat | Mostly | Definitely

Theme 14: compulsive eating / compulsive self relief parental

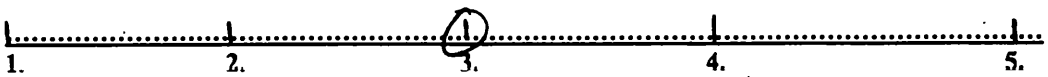


Not at All | A Little | Somewhat | Mostly | Definitely

Theme 15: attention problem - concentration

Not at All | A Little | Somewhat | Mostly | Definitely

Theme 16: Family conflict poor family functioning



Not at All | A Little | Somewhat | Mostly | Definitely

Theme 16: parents unable to offer appropriate care

Not at All | A Little | Somewhat | Mostly | Definitely

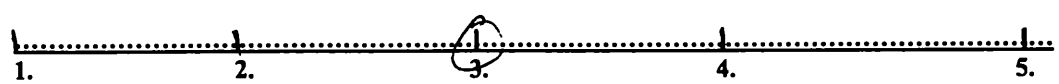
Theme 17: Communicating care giving / self neglect parental cruel

Not at All | A Little | Somewhat | Mostly | Definitely

Theme 18: Alternative parenting or extra almost figures

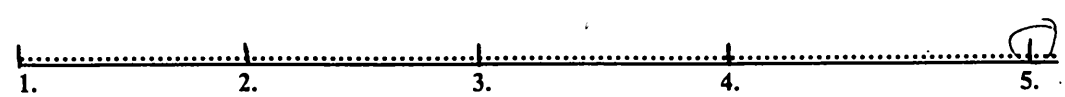
Not at All | A Little | Somewhat | Mostly | Definitely

Theme 19: Family conflict / poor family functioning



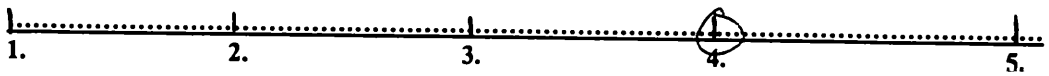
Not at All | A Little | Somewhat | Mostly | Definitely

Theme 20: parents unable to offer appropriate cruel/ continuous



Not at All | A Little | Somewhat | Mostly | Definitely

Theme 21: [illegible]

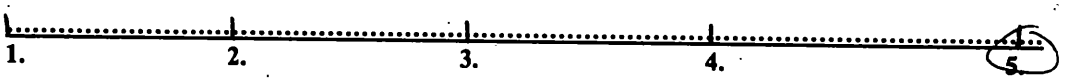


Not at All | A Little | Somewhat | Mostly | Definitely

Theme 22: [illegible]

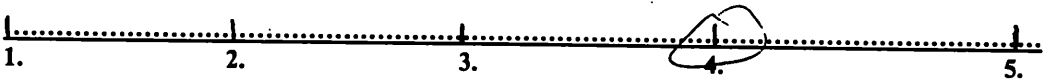
Not at All | A Little | Somewhat | Mostly | Definitely

Theme 23: [illegible]



Not at All | A Little | Somewhat | Mostly | Definitely

Theme 24: [illegible]



Not at All | A Little | Somewhat | Mostly | Definitely

Theme 25: [illegible]

Not at All | A Little | Somewhat | Mostly | Definitely

APPENDIX 20: Parental ARAQ scores on the four 'Patterns' of attachment, showing median, range, maximum and minimum, Chi-Squared and 'p' values.

PATTERN OF ATTACHMENT

Parent Group	AW	CCG	CSR	CCS
1. Eating Disordered (N = 7)	Median =12 Range =18 Max. =26 Min. = 8	Median =20 Range = 14 Max. = 33 Min. = 19	Median = 15 Range = 10 Max. = 20 Min. = 10	Median = 14 Range = 15 Max. = 23 Min. = 8
2. Depressed (N = 8)	Median = 14 Range = 6 Max. = 16 Min. = 10	Median = 22 Range = 7 Max. = 23 Min. = 16	Median =12.5 Range = 8 Max. = 19 Min. = 11	Median = 13.5 Range = 9 Max. = 20 Min. = 11
3. Control (N = 15)	Median = 11.5 Range = 13 Max. = 21 Min. = 8	Median = 25 Range = 16 Max. = 30 Min. = 14	Median = 15.5 Range = 10 Max. = 21 Min. = 11	Median = 13.5 Range = 13 Max. = 22 Min. = 9
	Kruskal-Wallis Chi-Square = 1.334 p = .513	Kruskal-Wallis Chi-Square = 2.882 p = .244	Kruskal-Wallis Chi-Square = .339 p = .844	Kruskal-Wallis Chi-Square = 2.507 p = .285

KEY:

AW = Angry withdrawal
CCG = Compulsive care-giving
CSR = Compulsive self-reliant
CCS = Compulsive care-seeking

APPENDIX 21 - Table showing overarching clusters and superordinate themes from interviews across the three groups of adolescents, showing commonalities and differences.

NB: Unlike Appendix 23 which lists *ALL* second-order IPA themes generated across the three groups and their allocated superordinate categories, this appendix shows only themes held in common by two or more individuals and lists how many transcripts each theme occurred within.

Themes common to all groups	**Family Relationships:** Influence of parenting experience on own personality/proposed parenting style (15/15) * **Peers/others:** Concern with peer relationships (12/15) Concern with romantic/sexual relationships (10/15) Problems with school/peers (10/15) Victim of bullying (8/15) **Symptomatology:** Family physical health problems (8/15) **Life Events:** Significant losses/bereavements (8/15) **Emotions:** Expressed fears/worries (9/15)
Themes common to clinical groups only	**Family relationships:** Parental lack of emotional containment (10/10) Poor family functioning (9/10) Parental conflict/separation (8/10) Parental rejection/neglect (8/10) Parental 'frightening behaviour' (8/10) Strict, authoritarian parent (s) (7/10) Reported experience of familial abuse/maltreatment (6/10) "Daddy's girls" (6/10) Family arguments/conflicts (6/10) Poor sibling relationships (6/10) Main attachment figures not parents (4/10) **Reflective Functioning:** Impoverished reflective capacity (10/10) Compulsive self-reliance/compulsive care-giving behaviour (10/10) **Symptomatology:** Significant mental health problems within the family (7/10) **Emotional Experiences:** Self-directed hostility/Low self-esteem (8/10) Secretive/withdrawn (5/10) **Emotions:** Anger/Aggression (7/10) Misery/despair (6/10) Jealousy (5/10) **Life Events:** Excessive instability/disruption during childhood (7/10) Experience of significant trauma (other than childhood abuse) (6/10) **Developmental:** Difficulties with sexuality/sexual development (7/10)
Themes common to Eating Disordered group only	**Family relationships** Highly competitive/ambitious parent(s) (4/5) Unusually sporty families (4/5) Over-emphasis on normality of family functioning (4/5) **Separation:** Family enmeshment (5/5) Significant early separation experiences (3/5) Current separation anxieties (3/5) **Symptomatology:** Preoccupation with talking about weight, shape, food and eating (5/5) **Life Events:** Significant early problem with food intake (3/5) Childhood physical illness(3/5)

Themes common to Depressed group only	**Family relationships:** Poor intergenerational attachment histories described (3/5) Protective relationships (4/5) Strict/Overcontrolling parent(s) (3/5) Main early attachment figures not parents (2/5) Lack of contact/support from extended family (2/5) Inconsistent parenting styles (2/5) Young, inexperienced parent (s) (2/5) Religious upbringing (2/5) **Separations:** Early separation anxieties (4/5)
Themes common to control group only	**Family Relationships:** Secure/close attachments to parents (5/5) "Happy childhood" (3/5) **Peers/others:** Close attachments to siblings/peers/others (5/5) **Reflective Functioning:** Good reflective capacity (5/5) **Separation:** Ability to individuate and develop own sense of autonomy (5/5) Ease with separations (3/5) **Emotions:** Good sense of self-worth/self-esteem (3/5) **Life Events:** Early stability (home, schools, parental employment) (5/5)

KEY

*** = Number of participants eliciting this theme**

APPENDIX 22: SAMPLES OF TWO WORKED TRANSCRIPTS

(SHOWING FIRST AND SECOND ORDER IPA THEMES AND THEIR GENERATION)

CHARLOTTE (16)

1. ***Could you start by helping me get oriented to your early family situation, and where you lived and so on? If you could tell me where you were born, whether you moved around much, what your family did at various times for a living?***

I was born in London and I lived there 'til I was 3 ...and my mum and dad separated from each other when I was three weeks old and, um, well, they don't talk to each other or anything now....um...and I stopped seeing my dad when I was three and he's never been in contact since really, since we moved up to Kent....So I don't see him at all...he's never sent a card, a letter, phone call to see how I am or anything....so I don't have no contact with him. My mum's been with my step-dad, well, he's not my step-dad, they're just together, they've been together for nearly, basically all my life, since I was 3...So I, like, class him as a dad, but then in a way I do wish I knew my real dad...And then when we moved to Kent we moved to X (town) first and then my dad bought a big house in ..have you heard of Y (village)?....It's just past Z (town)...and he bought a watermill there and he's been doing it up for years and we live there now...but we've moved around a bit...And I've lived with my Nan when my mum's been, like, an only parent with just me and when we lived in London my Nan used to always look after me and everything when she'd work in the day time and my Nan would be at work, my Aunty used to look after me, and when my mum would work of a night-time, then my other Aunty or my Nan and Granddad would look after me, so I saw my mum a couple of times, well a few times a day, really.....That was before my Granddad died and then we moved ....they looked after me for about three, four years, something like that...

So were you living with your Nan and Granddad during that time?

No – Well, ours was a bus journey away, really...or a drive, or whatever...but we didn't have a car, but my Aunty lived only down the road, but now they live around the corner from each other: you just walk round the other block and they're there....I was down there yesterday, 'cos it was my other Aunty's birthday....Only my step-dad's family live round here, all my mum's family live in London....So I don't get to seem 'em that often at all, 'cos it's a bit hard for us to keep travelling down there, 'cos none of them have got a car and so they can't keep coming up here...they catch a train down, but we go down there... couple of times a month, I think..something like that.

What sort of job did your mum do?

She done a print – she worked as a secretary of a print place during the day time and then of a night-time she used to clean for a big firm, with my other Aunty and another Aunty and her cousin...they all just used to do it together.

So she had the 2 jobs at the same time?

Yeah...she was out quite a lot 'n that....And my step-dad, he's a builder, but he does mostly mills and big work, he doesn't, like, do little things really..just does big jobs. My mum works at a Post Office now, and ...that's of a daytime, just on Mondays and Tuesdays and then on Tuesday nights she works at a care home..... yeah...cos we've got, I've got another little brother now, so.....she can't, like, go full time work 'cos then there's no one to pick him up, so I have to pick him up and then we have to walk to my Aunty's....

Do you know what your real dad does for a living at all?

Mmm...I know that my mum tried to ask him for money, like, for me, but he refused because he's got MS, but... he hasn't got it badly and he's got another kid as well, so if he can support her he can support me....and so.....In a way I don't want to see him 'cos he's out of order,

-Sense of injustice/ unfairness
-Feel rejected by F.
-Anger w. father
-Acting out behaviour
-Absent parents
-F. young when married
-Family secrets
-Victim of bullying
-Emphasis on money as sign of affection
-Not accepting
-S-father
-Significant loss/ bereavement
-Anger/ Aggression
-Family mental health problems in family
-Good memories of lost attachment figure (Granddad)

um, 'cos he was, like, really out of order to my mum and she just tells me loads of stories of what he used to do...not hit her or anything, he was just, like, a git really.....He was quite young when they had me, though...my mum's older than him, but he was about 18, 19..so I reckon that's one of the reasons why he didn't make a commitment...but still no excuse really, 'cos he didn't have...I was about 3 when my sister was born and he was still young then, so, um....he didn't even tell my sister about me...I phoned up once when I was about 7 and he wasn't in and my sister was on the phone and I said: "Is my dad there please?" and he hadn't even told her that I existed, which I found hurtful, really, 'cos I didn't know at first...it was only about a year ago that my mum told me that he phoned up and said: "Oh – I thought she had her own life now: I didn't think she'd be ringing me up still" , so.....I used to get, like., people at my old primary school saying(sneering voice): "YOU haven't got a dad" and that used to, like, hurt me...but.....

ANGER/ AGGRESS

VICTIM/ BULLYIN

Who would you say brought you up?

Jack. Me step-dad. He's like paid for everything...paid for me to go on school trips, bought me birthday presents: he's done everything really....But I don't call him 'dad': I don't feel comfortable calling him dad. I don't think I'd even call my real dad 'dad'...As far as I'm concerned, I've only got a mum..that's what I was brought up with mostly, sort of thing.....

You've mentioned seeing your grandparents quite a lot when you were little and that your Granddad died when you were a younger child....

Yeah...I was about 5 when he died and, like, I was so attached to my Granddad, it was unbelievable...And when we moved...He didn't want us to move. He said, like., I'll buy you a house down here for Jack to stay in and everything as well, but Mum was going: "No – we're moving, we're moving!" I didn't want to leave, or anything...He was, like, a very loud man and he could get very angry quickly, but he'd...I used to wind him up, which used to make him laugh, if you get what I mean, and he was always laughing and joking when we was little and every time we went he used to sit us on his knee and squeeze us really tight and rub his like, bristle (pointing to cheek) against us...so....I think he died of cancer, but then my Nan was so upset, she had a nervous breakdown after it.....*Mmm...that was hard*.....Yeah, it was...

SIGNIFICA LOSS/ BEREAVE

FAMILY M HEALTH PROBLEM

Do you and your mum talk about it much? About your Granddad?

Sometimes...We talk about the good times, we don't like say: "Oh , I wish he was still here", 'cos he was, like, really ill and that and so.....Me and my cousin Kirsty, she's older than me, she's 21 now...22....But when we was younger they used to take us on holiday. We used to always go down to the coast and we used to stay in a hotel and that and my cousin used to tell me that....'cos I loved my Nan as well so much... I'm still really attached to my Nan.....that I used to shove my Granddad out of bed...I used to cry until he got out of bed and like, so, I used to go and sleep with my Nan....But these bunk beds were only about that wide (indicates) and my Granddad he was a really big person as well, like, 'F' - ing and blinding and stuff like that (laughs) saying: "OHHH! Do I have to stay in this little bed!" And I didn't even know that...And other times where I'd say stuff like: "Oh! I want to go on the fruit machine!" and he was going "No! You're not going on there!" and I pressed one button and the jackpot come out and he was, like, really gutted.....*So, some good memories of him*....Yeah! Not a lot of pictures, though, which is not so good, sort of thing.....

SIGNIFI LOSS BEREAV

You mentioned a younger brother. Did you have other brothers and sisters living in the house now, or anybody besides your parents?

Separated/ disengaged family

Yeah – one little half- brother and one half-sister. But my half sister doesn't live with us, I don't really even know her…I know her name's Christine….I don't even know how old she is now..must be about 11, something like that….

POOR FAMILY FUNCTION

So she's your dad's daughter?

Yeah and my half brother is Jack's….He lives with us…We have our rows, but that's brothers and sisters for you, isn't it? And there's quite a big age gap, there's 7 years between us….He's nearly 8 now…8 in March…so….And he can be a little git sometimes, but then sometimes he's alright….Most of the time he's a little git, but…..he's at that age at the moment, I think….If I start to hit him 'cos he's hit me, then I'll get told off; it'll be me that gets told off, 'cos I'm, like, bigger and stronger than he is…. But I'm not! He is very strong…but. I just…I'm not…Well, I mean I am home sometimes but I just like stay in my room doing my homework really. I don't, like, um shut myself away from everyone but my brother's always on his computer, I'm always listening to my music, Mum's always doing cooking, Jack's always watching telly….And then when Bobby goes to bed, I come downstairs and sit with Mum and Jack, but Mondays I go out, Tuesdays I stay in, Wednesdays I go out Thursdays I stay in , Fridays go out, Saturdays and Sundays go out….So it's like in a rota… my Mum wants me to have a couple of days in to do homework and, like, clean my room or something…

- Aggression towards SIBLINGS
- Sense of injustice
- Separated/ disengaged family

POOR SIBL RELATION

POOR FAMIL FUNCTION

2. ***I'd like you to try to describe your relationship with your parents as a young child…if you could start from as far back as you can remember?***

- Aggression/ Jealousy towards SIBLING
- Anger/Aggression in childhood
- Worse in adolescence
- Jealous of S/F
- Euphoria on reunification
- Aggression/ hostility to step-mother
- Abusive/ physical abuse by dad
- Family violence
- Family history of violence

Well, um….I think it was quite good when I was an only child….Like, I didn't like it when Bobby was born..I had to …I was very jealous. I still am now. I'm a very jealous person…Um....but, um…As far as I know…they said I was a good kid when I was little and that…I did have my weird moments. Like if I didn't get my own way, 'cos I was an only child and spoilt by the rest of the family, then, yeah, I would stamp my feet and that, but otherwise I was quite a good kid..but it's just since I got into like secondary school that I've been the worst that they've ever seen me. But, um…yeah, I think we had a good relationship when I was young. I was always really attached to my mum 'cos I didn't, like, have no one else to play with or nothing, 'cos I didn't have no brothers and sisters….I didn't like it when mum and Jack got together….I hated it so much…*How old were you then?* Three..I hated it so much, I remember that….Like, he tried like, 'cos he had a really nice sports car and everything…he tried saying, like, 'there's little seats in the back for you', but I wouldn't, like, take any notice..'cos even though I was 3 I was stubborn, very stubborn and when we got to the house…he like made…'cos there wasn't a room for me, he like put an extension on and everything, just for me, to please mum and everything and made me a bed, 'cos the room was so small that it had to have a bed made…Like he provided everything, but I still weren't impressed..I didn't like him. I just preferred it just me and my mum…(pause) I did see my real dad before I was three, like every two weeks I think it was, but I hated my stepmother…she made me do things that I didn't want to do and she accused me of slapping my sister round the face…How can a 3 year old slap a, like, two week old baby round the face? …Which wound me up a lot and then we went swimming and she left me with one arm-band …- these are the things I can remember – she left me with one arm-band on up the deep end and she and Christine walked off. I was trying to swim…I was 3 years old…trying to get back…And then I got hit by my dad for walking off…How could I walk off and then all of a sudden get to one end of the pool, when I could only, like, swim with one arm-band on? I couldn't swim properly…..My mum had a fight with her, big time, BIG fight with her…punch up and everything. I remember leggin' it… it was why my dad..My dad's brother, Kevin was going out with my mum's sister, but he was always a really troublesome kid *Kevin was?* Yeah… 'cos their mother, she just didn't care about them…She had them and then left them for about three or four months and lived in Ireland and then came back…He's always in and out of prison now, but from the age of 14 he went into a child's prison, like a

ANGER/AG

JEALOU

POOR SIBL RELATIONS

ABUSE/ NEGLEC

POOR FA FUNCTI

detention centre thing and, like, my Aunty couldn't put up with it no more …this was about three years ago…four years ago now, so she like left him and then she found someone else…the person she's with now, Josh, he's really nice…But, like he broke into her house, shredded every single item of her clothes into pieces, nearly killed her dog and her dog's her pride and joy and…um…then the police arrested him and that, but um…..anyway, that's what sort of family they are, really…

Anything else about your step- mum from that time?

She was bossy..She's a tart. I just hate her for what she did to me..She got a really bad attitude…I just she wouldn't like…Yeah, I just wish my mum and dad were together 'cos then, like, I'd be one of my friends, 'cos their mum and dad's are all still together and mine ain't..but, er….It was hard when I was younger, 'cos people used to say "Oh, your mum and dad ain't together..you haven't got a dad". They used to say "Where is he?" and I used to say: "I don't know" and they used to say (sing-song) "You-ou haven't got a da-a-ad" It used to upset me so much…(pause)

3. ***Now I'd like to ask you to choose five adjectives or words that reflect your relationship with your mother starting from as far back as you can remember in early childhood – as early as you can go, but say age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think for a minute…then I'd like to ask you why you chose them. I'll write each one down as you give it to me.***

I can say between 5 and 11…*that's fine*….It was quite good. We used to, like, do everything together…I suppose it was strong…um….We were close together…um…I dunno….enjoyable, I suppose….

OK Great. Now let me go through some more questions about your description of your childhood relationships with your mother. You say your relationship with her was quite good Are there any memories or incidents that come to mind with respect to quite good.?

Um…When we used to go shopping together and when we used to get my new school stuff ready for the next term…She used to take me to town and we used to get loads of things..Um…When we'd go on holiday…We used to really enjoy ourselves together when I was younger….Um….Disneyland was the best one…I was 10 or 11….We'd all go on the rides together. I mean, my mum's still scared of them, but she'd like, go up on 'em anyway..so, like, we was all together and we'd go, like swimming together…That was a good holiday – I really enjoyed that….

You also described a childhood relationship with your mother as one where you did everything together. Can you think of a memory or an incident that would illustrate why you to describe this relationship as one where you did everything together?

Um….my mind's gone blank! Er…She used to take me and watch me doing gymnastics, dancing and majorettes…Yeah, that's it! Majorettes…I used to be a majorette, from the age of 7 to 11 and she was one of the troop, like, leader things..She used to help out with the whole troop..and so did my best friend's mum, 'cos it was like, there troop…we made our own troop up..So we used to get really involved in that…My mum used to have my leotards all ready for competitions..then we'd go on holiday for competitions at Pontins in April, I think the time of year it is and she used to like video and, like, take pictures of all my …um…solos and the group routines that we've done….and, um, there was one year that, um, me Kirsty and Sarah done a trio together..and they said "if you get through we'll get you tickets to go and see Take That – we were all mad on Take That – and we came third out of the competition and so we went and saw Take That and so it was…it was good in the old

days....(pause) *We'll talk a bit more about what things are like now a bit later on, 'cos I've heard you say a couple of times that it feels a bit different now*...Yeah, it does...

You also described your childhood relationship with your mother as strong. Can you think of a memory or an incident that would illustrate why you to describe this relationship as one that was strong?

When I was young I was very protective over my mum...VERY protective...I didn't like it like that she'd sunbathe on the beach..I didn't like anyone seeing her..um...I was always, like clinging onto her..when it was just me and my mum...It was just like a mum and daughter thing, just like for three or four years. I couldn't let her, like, out of my sight...I didn't want no one to see her....

You also described your childhood relationship with your mother as you being close together. You've said a bit about this already, but can you think of another memory or incident that would illustrate why you to describe this relationship as one that was close?

When we was in London, we had, like, our own house and that and um....I had my own bed, but I didn't like sleeping in it, so I slept with my mum, so that it would be just us together....I was about three or four...'Cos she had a funny relationship with Jack for about a year...She used to go up there every other weekend or something...so it was about three or four years...

You also described your childhood relationship with your mother as you being enjoyable. Can you think of a memory or an incident that would illustrate why you to describe this relationship as one that was enjoyable?

Like when she used to take me out and, like, spoil me and that....I remember the park that we used to always, always go to, round the back of our house...It used to have big climbing frames and, like, a little swimming pool...and I used to always go there. And also.... 'Z' park it's like a big, um, adventure playground thing with., like, wooden , like cabin things and aerial slides..She used to take me there when I was about 8....Sometimes she'd join in, push me on the swing or something, or catch me at the end of the slide...I don't think she ever used to go on herself, though (laughs)...

4. ***Now I'd like to ask you to choose five adjectives or words that reflect your childhood relationship with Jack, again starting from as far back as you can remember in early childhood – as early as you can go, but again say age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think again for a minute..then I'd like to ask you why you chose them. I'll write each one down as you give them to me.***

Um...Oh, I dunno....It was OK, um....but it um..it weren't strong really...It was fun, like going out and everything all together, he used to, like, take us to Chessington and things like that, but even so I, like, hated him, didn't want to know ...And he didn't really care about me either...yeah, I guess it was a bit uncaring, really.....
.... he used to...I don't think this is right...Even though he's been with my mum so many years, even when we were living in X (town) and I was just 6, so my mum had only been with him 3 years – 2 ½ - and he, like, used to hit me, sort of thing..Not like round the head, but he'd, like, smack me...I didn't think that was right, so I wasn't really too keen on him if you get what I mean. He doesn't hit me now, but that's 'cos I wouldn't let him now. He went to last year on holiday and I said "You dare hit me and I'll get the authorities", so he didn't...I'd had a massive argument with mum and he got involved and I was going "Just keep out of it, it ain't got nothing to do with you...And my mum was going to him "Go on, hit her, hit her!" and I was going: "Shut Up!" and so he went to hit me. He cornered me in the bathroom and I went to him "You dare hit me or I'll get the authorities and he just, like, pushed me and said "Shut up and go to bed!" and I went: "Don't speak to me like that – You ain't my dad, you

Insight/awareness

Anger/resentment

Anger/Aggression towards S/F.

Rejection of Step-father

can't tell me what to do!" I suppose I shouldn't have said that, 'cos it does hurt, but I wish he wouldn't do things like that and I wish mum wouldn't say things..'Cos it really does wind me up...I just can't wait to move out...When he first came along I was like "My mum – I want my mum!" And when my granddad died, mum went to London and I wasn't allowed to go to the funeral, 'cos I didn't know at first..um...Jack had to look after me and, er, he used to have to, like, do my hair in the morning and he couldn't do it....He used to, like, make a right mess of it..but..Yeah, we did have some fun times, but I wouldn't class them as absolutely brilliant...I wouldn't classify the times I've had with my mum as absolutely brilliant either....But, um...yeah..I do get on with him...I can talk to him ...but...I dunno, there's just, like something there that I don't like about him.... Through the years it did get better, like when we used to go to the park and he used to, like, pick me up and everything, so it was strong afterwards, but at first I, like, didn't have no affection for him at all, I just didn't, like, care..I just didn't want him, I just weren't impressed at all...But, um, now I can talk to him, but I can talk to him more as a mate, not as, like, a father figure.... I just talk to him friendly and not like...well, I **can't** talk to him different, I can't talk to my mum so....I talk to my Aunty the most, but it's hard for me to always, like, phone her or see her 'cos she lives in London, so it's a bit hard....I didn't want to move...Not at all.....

ANGER/ AGGRESSION

Okay, now let me go through some more questions about your description of your childhood relationships with Jack. You've told me about the relationship not being strong You also said that your relationship with him was fun sometimes and you've told me a bit about that.. Are there any other memories or incidents that come to mind with respect to fun?

Some good memories with Step-F.

We used to go on holiday A LOT, 'cos my Nan used to own a villa in Spain...We used to go out there, like twice a year, so he used to come with us and, um, we used to have really good times there, 'cos we used to go to this massive water park and we used to go on the really big slides..While, like, my mum's frightened of everything, so she, like, wouldn't go on and I wanted to go on the big slides, so Jack used to put me on his lap...so we used to have quite fun times going to theme parks and swimming pools and fun on holiday, going to the beach...So parts of it used to be quite good....

You also said that you hated him/didn't want to know: .. Are there any other memories or incidents that come to mind with respect to hating him/not wanting to know?

- Physical abuse - Step-Father
- Angry/Aggressive feelings towards S/F
- Emphasis on materialism
- Suspicious of S/F's motives
- Feeling displaced by sibling

Well, just what I was saying really before about him hitting me, and that....I didn't want to get to know him....One time he decorated all my room for me and put in a new shelf and everything and there was a windowsill and I wrote in biro all over this windowsill "I hate everyone, I hate everyone"...I was about 6 – I could, like write, so yeah, about 6 and he went mad. He'd spent loads of money decorating this room and I just, like, destroyed it...He didn't say anything to me, he said he was mad to my mum, 'cos he'd, like., bought loads of teddies and everything to put in this hammock that he got me and I had this hammock full of teddies and a guitar – don't know why he bought me a guitar - and a new telly, new wardrobe, new clothes, new shoes...He bought me absolutely everything, but I think that was just, like, to win me on his side...As soon as my brother, Bobby come along, he didn't want to know...'cos it was his flesh and blood, basically.....When Bobby came, everyone paid the attention to the little baby, which is understandable but it still hasn't changed ..It's still all for Robbie and where John would, like buy him things...like Bobby's mad on football, right and I used to really like football: I used to be a bit of a tomboy; I used to love football and I had to save up - I used to be able to save – I can't now – to save up about £60 to buy this football kit that I wanted – the Liverpool football kit, but as soon as Bobby started liking football, Jack bought him every single Chelsea kit...we all support Chelsea now...but, like, he bought him the new Chelsea kit for his birthday and then, another new one come out a couple of months later and so he had to get that – it weren't for no reason at all – so he had to get him that...He bought him loads of football boots, 'cos he was starting football...uh, he was just really

ANGER/ AGGRESSION

POOR REL WITH SIBLING

JEALO

spoilt..he's got about 5 Chelsea kits now and I've got one Chelsea shirt and that was only 'cos it was in a sale in the catalogue, but....Bobby just gets everything...If he don't get everything that he wants...I suppose I was a bit like that, but I weren't as bad....I know for a fact I weren't as bad – I used to appreciate everything I got. With Bobby, at Christmas, he'd open something and be like: "Oh! I really didn't WANT that!" he'd be really horrible and nasty..that's what he's like, though...Basically it feels like Jack shows all his love to Bob and none to me..It don't bother me now anyway – it used to – a lot – but it don't bother me now. It seems to me like my mum does it most of the time as well that at one point she couldn't do anything to stop me from doing what I wanted to do and it just used to be "Oh! Bobby! Bobby! Bobby! Buy Bobby this, buy Bobby this, buy Bobby that! Like every time they used to go out, he'd get something new..like..new trainers – Oh! That was it! I needed trainers desperately, 'cos they was all coming away at the sides, and Bobby's were perfectly fine: he'd just got a pair and they were brand spanking new and he started crying and stamping his feet in the middle of the street when my Aunty looked after us for a week – we go down to London in the 6 weeks holiday – and, um, just because I was getting a new pair of trainers, she said "Oh, Charlie, you need a new pair of trainers!" And Bobby's like: "I want a pair of trainers, I want them now!" So my Aunty's phoned up my mum and said: "I'm buying Charlie a new pair of trainers, but Bobby's are perfectly fine and he's stamping his feet and everything...can you tell him not to be naughty and she's, like, 'No! if you're going to buy for one, you've got to buy for the other – buy Bobby a pair of trainers as well!' So my Aunty went furious, she was, like, going mad at Bobby..So he ended up getting a pair, but while I wear mine, like, out, he doesn't go 'out – out', where I wear mine out, I need a pair, like, every six months or something...His last for ages, but he gets them every time I get them, so I think that's unfair....I suppose it's jealousy and I'm just being like a spoiled brat really, but....it just seems like it's favouritism to him rather than to me.....

And finally, you said that Jack didn't really care about you..You've told me a bit about this in relation to Bobby, but are there any other memories you have about the relationship being uncaring?

....Jack never used to come on holiday with us to watch – yeah – he never come on holiday with us to watch me do majorettes and I used to absolutely adore majorettes: I've got loads of trophies at home – it was my pride and joy....everything revolved around majorettes for me...and with Bobby, he goes to watch Bobby play football, like, every week...goes to his training...goes to his matches and everything, but just 'cos I'm a girl and I done majorettes which is, like, a girly thing, he never used to come and watch me do my competitions which are really important..um...like, he never used to come and watch me do my training – like, my majorette training, or he never used to come on holiday with us to the BIG – big competitions against the whole country....My mum came twice out of the many years that I've done it and the rest of the time I went with my friend's mum, so...Mum used to get involved when we had our own troop, but before that, when I was with a different troop, she never used to....Everyone just gave up on majorettes in the end, as soon as we started secondary school...they all thought: "Oh, we're too big for that now!" ...It was really fun doing majorettes, I loved it! I used to do carnivals, displays, everything really...Jack never used to come and watch me once and so I was really angry with that!

5. ***Now, I wonder if you could tell me, to which parent did you feel the closest, and why?***

My mum, definitely....My real dad, like, didn't even want to know me and I never really liked Jack, like I said....Although in some ways I was closer even to my Aunty and my Gran and Granddad, til he died, than to me mum...sometimes just find it easier to talk to me Aunty and that...perhaps 'cos I don't live with her. I just wish she wasn't in London.....

Why do you think that this feeling wasn't there with Jack?

Well, Jack, like I said, 'cos of what he was like with Bobby and everything and how he just dumped me when Bobby was born and ....hitting me and that...I thought that was out of order...Mum, I dunno...just mothers and daughters, I guess, or maybe that was Bobby too...she changed towards me when Bobby was born and 'cos I never accepted Jack, really, 'cos he was never my dad and I didn't like him much and that...I just got on better with my aunties really....

6. When you were upset emotionally as a child, what would you do?

Scream..stamp my feet, anything...They had to lock me in a room once to calm me down, 'cos I was going absolutely mad...I tried to kick the door down – made a hole in the door because I was so angry and I was only about 4...I had a really bad temper, really, really, bad temper.....It was probably that I hadn't got my own way or something, or that I didn't want to go bed, or something....or I was just really tired and ratty...I just used to stamp my feet and, like, lash out really when I was younger....I cried too....a lot...Don't really so much now...Mum used to make little comments and that saying: "you're just like your father – you got the same attitude as him!" When me and mum weren't getting along, right, I'd say just one thing and apparently I'd sound just like my father and then I'm a 'nasty piece of work'....'you're just like your father...blah, blah. blah'. I just thought: "how can she say that when I don't even know what he's like? I haven't seen him since I was 3 and how can I be like him if I dunno what he's like...I suppose it's inherited"

Can you remember what would happen when you were hurt physically?

On purpose...or accident? ...*Either*...Well, this scar there (points to forehead) I was running too fast in my Aunty's house and she had metal door frames and it was really sharp and I whacked right into it and...you know on cartoons and that they have a big bump and it come out like that and my mum said that it looked as if it was just about ready to explode...I've had that scar all my life! I can't think what else.....When I was in primary school, a fire extinguisher broke my toe, 'cos it fell on it...Playing netball I broke my finger...um...er...I've, like, smacked myself in the mouth with a baton when I was going like that (motions arm upwards) and got myself like that...big bruise like that.... I used to always moan, 'cos mum and Jack never did: "Oh! Are you all right? Are you all right?" They always used to....Like, I remember, I cut my foot outside one time and it really hurt and was bleeding everywhere and they just said "Oh, you should've been wearing slippers, or shoes, or something!" I was pouring out with blood everywhere and they were like: "go and put a plaster on it!" And I was like 'Oh! Great! Thanks!' ....

Were you ever ill when you were little?

German Measles. I think that's it....I think I was only about 6 months old..so I don't really remember...And I got Chicken Pox when I was 11 – caught them off Bobby! I had them really late....It was horrible! I hated it! I never had 'em before and I had a majorette competition, so I was really angry, 'cos I had all these spots everywhere and I thought: "Oh! They're just going to think I'm a really spotty kid...And I had this really nice leotard and I, like, couldn't wear it 'cos the back went all down like that (indicates) ..And I had all these chicken pox all down my back and they looked really horrible, so my mum had to buy another one and that went all the way up and had a big collar...So you put loads of, like makeup on...Mum helped me put makeup on and try and cover as many as she could..I wore skin coloured tights to try and cover 'em, but that didn't really work...but I still come first, so that was quite a result (laughs) !...Mum kept putting the calamine lotion on my back to stop it itching...but I just used to sit there and do nothing...it was crap! I felt awful!

I was just wondering, do you remember being held by either of your parents at any of these times- I mean, when you were upset, or hurt, or ill?

I was just wondering, do you remember being held by either of your parents at any of these times- I mean, when you were upset, or hurt, or ill?

No. I don't remember any. But I dunno....no, I can't remember...

7. What's the first time you remember being separated from your mum or Jack, after he came to live with you?

From my mum was when she had to go to London 'cos my Granddad was dying....She came back...It was only for a few days or maybe a week...I'm not too sure...

How did you respond?

I can't remember.....I only know that 'cos John had to do my hair and I had really really long hair, blond hair, down to there (points down her back) and he tried putting it up in a pony tail and it was all bumpy everywhere and....ugh!.. so I had to wear my hair down and I never wore my hair down at all....I used to always have it up in a pony tail...but when I was little I used to have short, short hair...that was when I was about 5, then I had really long blonde hair.

Do you remember how your mum responded to that first separation from her?

No....not really.....

And are there any other separations that stand out in your mind?

Well, I don't know...some people get upset when they leave their mum...but as soon as I reached the age of about 10 I didn't ...well...I did care but I wasn't that bothered that I wasn't with my mum...I mean, I used to always go on holiday with my friend....I was 7, actually...it was with my best friend, Kirsty, we used to go to Pontins every single year and like, I used to stay round my house on a Monday so we could go to majorettes and then she used to stay round my house on a Thursday and we used to go Brownies, so I was always away from my mum and it didn't really bother me or anything...but when I was younger it did...a LOT. But as soon as, like, Bob was born and Jack was permanently there I just didn't care....

..I also remember going on holiday with my Aunty and that..going for about 3 weeks without my mum...I don't really remember how I reacted about that, at all....I was only about six, I think, when we went to Gran Canaria....then we went to Alicante..I'd just come back off holiday with my mum and dad to Alicante and went again with my Aunty about 4 weeks later – back to the same place, exactly the same house...so....I remember going on holiday as, like, a big family, without Jack, 'cos he weren't known of....Just this big family. There used to be my Granddad, my Aunty, my other Aunty, my Mum, me, Kirsty...It used to be all girls...my Granddad was the only boy...He hasn't got no sons or anything...and he didn't live to see Bobby be born and I suppose that's...quite bad...but we used to always go on holiday as a big family...and love it...It used to be great...we used to go to Portugal, Alicante, used to go like every year and sometimes even twice a year...But I can't, like, remember how I felt when I was separated from my mum...I'm not too sure...

8. Did you ever feel rejected as a young child? Of course, looking back on it now, you may realise it wasn't really rejection, but what I'm trying to ask about here is whether you remember ever having felt rejected in childhood?

By my real dad – a lot by him. But, then again as well like I said by Bob: when Bobby was born....just being placed out of the picture, really....everyone's emotions were like around

step-grandchild and everything…I'm the only, like, one…and there's loads of 'em…there's like 14 grandchildren or something…..I don't, like, get put out of the picture by them or anything, I'm classed as one of them which is good, but I know deep down inside that I'm….I don't know…I do get on with them, but I just wish so much that I lived back in London…..and I wish I could take all my friends with me, so I could be with my family again.

REJECTION/ NEGLECT

Feeling left out/ different
Feeling isolated

Why do you think your parents did those things- do you think they realised they were rejecting you?

Rejection by F.

I just thought my real dad didn't care. If he could leave a baby at three weeks old and, like, I stopped seeing him at 3. He's got every single one of our addresses…..every time we've moved, we've always given him our phone number…like we've given them to my Aunty to give to him…but he's phoned..he's never got in contact AT ALL. That just says to me that he don't care and that does upset me 'cos he shouldn't have, like, made me if he's not going to care about me, not going to talk to me or anything…Oh!. ..I just wish he'd be more, like, you know…..It does wind me up so much to think that he don't care…I don't know whether he does care or not, or if it's me that he don't…….

ANGER/ AGGRESSION

Anger towards natural F.

REJECTION/ NEGLECT

Feeling unloved/ rejected

↑ Low self-esteem

With Bobby, I don't know….When they first told me that "you're going to have a new brother or sister" I started crying and said I didn't want one and they said: 'it's a bit late, you're getting one no matter what!' and I didn't like it…..It was like, when he was born everything was like, BOBBY, and I just got so wound up with it, even at that age…Like: "Shush the baby's asleep!" "Don't do that, you'll wake the baby!" "Don't do that, you'll upset the baby!" "Don't pull that face: that's a scary face!" It was so, like, stupid!….I still feel like it now, 'cos he's the youngest and that and my cousin 'cos she's like 22, she seems more like an Aunty and less like a cousin, so it seems like it's just like me and Bob who are younger….He just winds me up so much…..

Jealousy/ Anger towards sibling

- lack of parental understanding

9. Were you ever frightened or worried as a young child?

Yeah. I did when I was little. I remember once I got a red lipstick and completely destroyed my Aunty's room…and she like had just put on white covers and, like, a grey carpet and I just like covered the whole room with this red lipstick, so I remember that…And then they thought I was, like, one of 'em possessed children..like where they've gone a bit loopy, they thought I was one of them…Only joking about and that, right, 'cos um… my cousin was babysitting me and she was watching Freddy Kruger and I kept going to her like (slashes with finger nails across her face)… and mum said I used to always be in a daydream and just stare in a trance across the floor….She'd say: "What are you staring at Charlie?" and I'd say (sinister voice): "A baby!"… We were still living in London, so I must have been about 3..4..and they said it was quite scary seeing me like that, 'cos I used to always just stare at this thing on the floor…and then my cousin said that I was really scary, 'cos I used to say, like: "I can see a dead baby on the floor!" "I can see a dead baby!" …I don't know whether I was that frightened myself at the time, 'cos I don't really remember it, but when they told me later, I was like "Oh, my God – I didn't think I was like that!" …And it was really embarrassing…Yeah, but I don't mind embarrassing stories…. 'cos I don't get like that!

? Problems as a younger child

ANGER/ AGGRESSION/ SIBLING

Anger/Aggression towards sibling (I wished S/S was dead)

10. Were your parents ever threatening with you in any way – maybe for discipline, or even as a joke?

Avoidant/ Cut-off from experiences (contradicted by evidence elsewhere)

No….(silence)

Some people have told us, for example, that their parents would threaten to leave them or send them away from home..Did anything like that happen to you?

FIRST-ORDER THEMES:

SECOND-ORDER THEMES:

LUCY (16)

10. Were your parents ever threatening with you in any way – maybe for discipline, or even as a joke?

Yeah…I used to be terrified of my dad….If I used to do something, I used to know I was going to get smacked. I remember I used to leg it up to my room and often it wasn't even the actual smacking that used to scare me, it's just that I knew….I think it was more of a scare tactic than anything, made me realise never to do it again….I remember…I don't know what I did, but I remember one time standing on my bed and my dad walking into my room and, I don't know why, but I remember just being terrified…..I knew he was going to flatten me….I can't remember what I did, but I know that I never did it again (laughs).

ABUSE/ MALTREATMENT

How old were you?

Probably about 5 or 6….It was always dad rather than mum…I only ever remember my mum, well she didn't actually hit me, but I remember once, I don't know what I did, but it was when I was living in [redacted], and I was standing at one end of the room and she was standing at the other and she threw a slipper at me and it hit me across the face (laughs) I remember that, but I can't remember what I did….but that's one of the only times…(*mmm…..*) /*pause*/

Some people have told us, for example, that their parents would threaten to leave them or send them away from home..Did anything like that happen to you?

(FELT) REJECTION/ NEGLECT

No..I mean, they spoke to me about going to boarding school before we moved to *(foreign country)* and I would just go into my room and start packing and say (imitated distressed crying voice) "I'm going, I'm not going to let you send me away to school" and everything…but no, not at all…./pause/

Some people have also told us that their parents would use the silent treatment – did this ever happen with your parents?

(EMOTIONAL) ABUSE/ MALTREATMENT

My mum. It's mainly now though…I think my mum has realised now that yelling and screaming at me doesn't actually do much good, 'cos I would just yell and scream back…but the silent treatment from my mum, or both my parents really, works a lot better….cos that really gets to me….(*mmm….right*) /pause/

ANGER/ AGGRESSION

What affect does it have on you?

Guilt, I just feel really guilty…I probably end up giving in and apologising…

LOW SELF-ESTEEM SELF-DIRECTED HOSTILITY

11. Some people have memories of threats or of some kind of behaviour that was abusive. Did anything like this ever happen to you, or in your family?

(v. quiet) No…no…not at all /pause/

Did you have any such experiences involving people outside your family?

ANGER/ AGGRESSION

(quiet and sombre) I suppose so, yeah…..I don't know, I suppose, just with the people I hang out with and everything…just getting into fights more than anything….cos I was normally the only girl, with older boys….I'd normally get started on first, but I suppose I can stick up for myself quite well….Mainly at school and those sort of things, I'd be maybe on one side of the playground and they'd be on the other and everything and they'd just….I never really got into the physical fights, usually, but I'm very good with verbal fights….That's probably been from when I was about 9 all the way up to now….I never really got picked on when I was younger,

'cos I suppose I was taller than most of the blokes, so they were always a bit scared of me....but I suppose I was bullied when I was in about year 8 and I just ended up turning it on myself and ended up hating myself more than anything..../pause/

A difficult time for you....

Yeah...and still is, cos these boys are still immature prats who think it's highly amusing to take the piss out of me, cos they know that it'll get to me.... They just make comments, stupid petty comments that you'd expect to get from a 9 year-old....And this bloke just happens to be going out with my best friend at the moment, so I can't get away from him very well....

How do you feel these experiences affect you now?

Knock my self-confidence, I suppose... I mean, I hate myself anyway, but when they start saying things like that it just makes me feel even worse, more than anything.../pause/

Any other such experiences involving people outside your family?

Not really/ pause/

12. In general, how do you think your overall experiences with your parents as a younger child have affected your personality now?

I suppose I don't really remember them that much, so they haven't really affected me that much, or the way I feel now....It's almost as if I have, like, a mental block...I mean....my memory is really bad and I don't remember, like my first couple of years at X (boarding school) because they were probably bad memories and it's almost like I have a mental block...like anything before I was about 13...I mean, I can remember different things, but I expect ...It may have subconsciously effected me, but I can't think of ways that it's affected me.../pause/

13. Are there any aspects of your early experiences that you feel were a setback in your development?

Probably the fact that my parents weren't there a lot...., made me feel quite alone, I suppose...and then I went to boarding school...Don't think there's anything else...I don't really remember things!

14. Why do you think your parents behaved as they did during your childhood?

My dad had to move, basically...My parents just made the decision that if we were going to have to move, it would be better if we all moved together...And they did that for us, basically, cos they didn't want....otherwise I would have basically grown up without a father really....I'm quite glad they did. Part of me feels bad, cos, I mean, I've never had a best friend, really...and I've never had a friend for more than 2 ½years, but at the same time, I have friends whose parents made the other decision, like one of my best friends, who lives down in ....., he's got a really bad relationship with his dad and everything, cos his father, his grandmother, decided that she would stay where they live...and everything...so I think that they (my parents) probably made the better decision....And also I've seen quite a lot of places in the world that most people haven't and everything....*(mmm.....)*

15. Were there any other adults with whom you were close, like parents, as a child?

PROTECTIVE RELATIONSHIP

Probably mainly my grandparents....I have a friend that I've known since I was about 3 and her parents and I still know them now and I still go and talk to my friend's mum....When my mum was like, despairing, or something, she was quite placid and calm as well and everything and I know I can just talk to her, cos she's been there since I was very little, as well, but at the same time, it's almost like having a mother, but she's not my mum...it's nice being able to talk to her...No one else, really, not that I remember.../pause/

- Mother mental health problems

FAMILY MENTAL HEALTH PROBLEMS

Or any other adults who were especially important to you, even though not parental?

Don't think so.....

16. Did you experience the loss of a close loved one when you were a child – for example, a close family member?

CUT-OFF / AVOIDANT

I lost my grandmother, but I don't remember it at all. It's really weird, I just have no memories about it at all, so not really, no...I was five or six, I think, but I don't remember it, not at all.... It's not something we've ever really talked about, either....

self memories Family don't talk loss?

Do you know if you went to the funeral?

I don't think I did. I think it was when we were living in 'X' and I think just my dad went...

Would you say that this loss had an affect on your personality now?

Probably not, cos I don't really remember anything about it....

Did you lose any other important people during your childhood?

No.

OK. No one else that you were close to who has died more recently?

No.

17. Other than any difficult experiences you've already described, have you had any other experiences, which you would regard as potentially traumatic to you?

No...don't think so. Not from like my younger childhood, really. Maybe more recently/pause/....

substance misuse self-destructive sexually invested self-blame

Can you tell me about that?

TRAUMATIC INCIDENT (other than parental abuse)

Well, more when I have gone out and got drunk, I suppose..... I've had some bad experiences with blokes who've tried to take advantage when I've not been in the most sober of states....I ...um, a bloke tried to make me have....a bloke from school...I did like him, but he tried to make me have sex with him on a park bench in the middle of a graveyard (laughs) (*mmm...*), which, I wasn't going to have any of it, really....just stuff like that...It was my own fault, really, I shouldn't have let myself get into the situation, but....this was, like only last year, or maybe two years ago, when I was 13, 14.....

SELF-DIRECTED HOSTILITY / LOW SELF-ESTEEM

What did you do?

I can't really remember. I think I probably went back to the party and had a few more drinks (laughs) to be perfectly honest with you! I didn't actually think about what had actually happened until the next morning and everything and then I was like; "Oh, my God – that was very close!" I don't know how we ended up in a graveyard, I think it was just near the pub, or one of the pubs that we were all in... The party was in Y (place), where a friend of mine lives and I was over there a while ago and she said to me: "isn't this the pub where the party was, and I said: 'I don't know, is it?' I had no recollection whatsoever... He's left now... I think he was very drunk as well..I didn't really speak to him much at school, 'cos I was year 10 and he was like, Upper Sixth, so....

What impact did it have on you, do you think?

I was a lot more wary...(*mmm... ...*)

Sounds like it was quite scary.

Yep. It was.

Did you talk to anyone about it?

Not really. Couldn't...Didn't tell mum and dad, they never would have let me go to a party ever again! /pause/

Did any other similar instances happen that felt frightening or traumatic like that?

No.... No, nothing.

18. Now I'd like to ask you a few more questions about your life more recently, say between 12 and now..

Have there been many changes in your relationship with your parents during that time?

Yeah...I guess I'm closer to them in some ways, but at the same time, I'm very independent and I like being able to cope with things by myself...I don't like being their little girl, I suppose, cos I don't see myself as that at all...I think me and my mum have a better relationship, 'cos we're much more able to be mature about situations, same with my dad really...Me and my mum are still very stubborn, though (laughs)! If we get into an argument, neither one of us will give up...That's it really.

And friends?

I've lost a lot of my friends in the sense of, like, I've had to leave them and everything, especially in *(foreign country)*, cos people only lived there for, like, 2 ½ years and you could make a friend and then they could leave, but not recently....When I left *(foreign country)* I left some friends who I had been with for 2 ½ years and everything....I tried to keep in touch, but when you're about 11 or 12 it's not really that important. It's like I know I'm leaving boarding school at the end of this year and going to college, and I'm determined...I know I'll keep in touch with my friends from there because it's a lot easier to now...I can just e-mail them and everything.../pause/

And romantic relationships?

I've been out with quite a few blokes...but I've never let anyone close to me...never been around long enough anyway...I am pretty wary of getting too close...

19. What would you say the relationship with your parents is like right now?

Quite good. I mean, I feel protective about them, which people say I shouldn't..Like I'm really worried about how they're going to cope with things before I am. Like if I'm in trouble in school or anything I don't like them being involved, 'cos I think it's going to hurt them, I feel really guilty...but, I mean it is quite good. I mean, we can talk a lot more, but I still find it very difficult to talk about things, with anybody. I think I mainly find it difficult to talk to them 'cos I feel guilty that I'm going to hurt them, or something. I almost feel responsible for my parents, for some really weird reason....The relationship is better, more mature, more understanding....about it really.

Do you have much contact with your parents at present?

Not that much. Every few weeks, really...I go home. It would probably be even less than that cos they're now living 2 hours away, but cos my little brother's new at boarding and everything, he loves going home, but I'm not that bothered. I go into town with my friends and spend the whole day shopping, but my little brother likes going home a lot more....

So what do you do if there is something on your mind?

I keep it. Don't talk to anyone. At the time, I'm much better at keeping it to myself, 'cos what happens later is that I finally explode!

You don't tell anyone?...

Well, more recently I've told 'Z' (Psychiatrist). She knows most of it...

20. Is there any particular thing which you feel you learned above all from your own childhood experiences? I'm thinking here of something you feel you might have gained from the kind of childhood that you had.

Um....I'm trying to think...I suppose I've gained the fact that...people need their own space and everything, especially being at school. I've learned a lot more about myself in some ways, I suppose, because....Well, I've gained a lot of independence, I suppose, just being able to deal with situations by myself and things like that, I suppose.

21. We've been focusing a lot on the past in this interview, but I'd like to end up looking quite a way into the future. We've just talked about what you think you may have learned from your own childhood experiences. I'd like to end up by asking you to imagine that in the future, you have a little girl of your own. What sort of parent do you imagine you would be to her and what do you hope she might learn from her experiences of being parented by you?

(Laughs) My worst nightmare!... Well, if I was the same as how I am now, they probably would have had hell...I don't know...I hope they will have learned, that no matter what anybody says, it doesn't really matter who you are, you are still acceptable...that if you have a problem, you should be able to talk to people and things like that...I hope for me too, that one day I'll be able to accept myself, that one day I'll be able to walk into a restaurant, eat a meal and NOT feel like shit afterwards..just things like that.....

How do you think you would feel if you had to separate from this child?

Probably absolutely heartbroken and distraught...the worst scenario....

Do you think you would ever feel worried about this child?

Yeah....What are they doing? Are they hurting themselves? Whose looking after them and everything....

If you had three wishes for your imagined child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your child.

That they were happy...that they were happy with themselves, mainly. That they knew what they wanted to do with their lives....and, I suppose, that they were in a position where they could go and get it....I suppose to get a good job and be able to look after me when I'm older (laughs). I suppose just that they'd be able to look after themselves and not get themselves into too much trouble (laughs) and..just be happy, really.

End.

APPENDIX 23:

Full list of second-order IPA themes with accompanying superordinate categories

This Appendix lists all the second-order themes emerging from transcripts within each group and the superordinate category or cluster these were placed beneath. It is acknowledged that some themes were appropriate to more than one cluster, but the cluster thought to be most relevant for that theme is listed here. It is also acknowledged that some themes seemed more relevant to their superordinate category than others did.

Eating Disordered Interviews

Comorbid group (N=3)

THEME	SUPERORDINATE CATEGORY
Neglectful/Absent parents	FAMILY RELATIONSHIPS
Disruption/isolation through moving	LIFE EVENTS
Main early attachment figures not parents	FAMILY RELATIONSHIPS
Inter-generational history of poor attachment relationships	FAMILY RELATIONSHIPS
Emotionally cut-off	EMOTIONS
Avoidant/dissociated narrative style/ impoverished reflective functioning	REFLECTIVE FUNCTIONING
Compulsive Care-giving behaviours	ATTACHMENT STYLE
Compulsive Self-Reliance	ATTACHMENT STYLE
Lack of parental emotional containment	FAMILY RELATIONSHIPS
Family mental health problems	SYMPTOMATOLOGY
Poor parental (marital) relationship/ Threat of parental separation	FAMILY RELATIONSHIPS
Family physical health problems	SYMPTOMATOLOGY
Family conflict/Impoverished family functioning	FAMILY RELATIONSHIPS
Reported experiences of parental abuse/ Frightening behaviour	FAMILY RELATIONSHIPS
Family history of abuse/maltreatment	FAMILY RELATIONSHIPS
"Daddy's Girl"	FAMILY RELATIONSHIPS
Fears/Worries	EMOTIONS
Inconsistent parenting styles	FAMILY RELATIONSHIPS

Overprotective/Intrusive parent(s)	FAMILY RELATIONSHIPS
Self-directed hostility/self-destructive behaviour/ low self-esteem	EMOTIONS
Separation anxiety/enmeshment	SEPARATION/INDIVIDUATION
Reported experience of trauma (other than parental abuse)	LIFE EVENTS
Victim of bullying	RELATIONSHIPS WITH PEERS/OTHERS
School/peer problems	RELATIONSHIPS WITH PEERS/OTHERS
Significant losses/bereavements	LIFE EVENTS
Identification with the opposite sex	DEVELOPMENTAL
Anger/Aggression	EMOTIONS
Significant early separations	SEPARATION/INDIVIDUATION
Family unemployment/financial problems	LIFE EVENTS
Parental substance misuse	SYMPTOMATOLOGY
Secretive/withdrawn	PERSONALITY
Competitive/ambitious	PERSONALITY
Depressed/suicidal feelings	EMOTIONS
Emphasis on closeness/normality of family functioning	FAMILY RELATIONSHIPS
Preoccupation with food, weight, shape and eating	PERSONALITY
Poor relationship with sibling(s)	RELATIONSHIPS WITH PEERS/OTHERS
Early problem with food intake	LIFE EVENTS
Rebellious	PERSONALITY
Sexuality/Sexual orientation	DEVELOPMENTAL
Adolescent Substance abuse	SYPMTOMATOLOGY
Influence of own upbringing on personality and proposed future parenting style	FAMILY RELATIONSHIPS

<u>Non-co-morbid group (N=2)</u>

Disruption/isolation through moving	LIFE EVENTS

Separation/individuation problems & family enmeshment	SEPARATION/INDIVIDUATION
Emphasis on sameness/dislike of difference	SEPARATION/INDIVIDUATION
Emphasis on 'normality' of family functioning	FAMILY RELATIONSHIPS
Sporty families	FAMILY RELATIONSHIPS
Very active families	FAMILY RELATIONSHIPS
"Daddy's girl"	FAMILY RELATIONSHIPS
Competitive families	FAMILY RELATIONSHIPS
Significant Losses/Bereavements	LIFE EVENTS
Experience of trauma (other than parental abuse)	LIFE EVENTS
Strict/Insensitive/Controlling parent(s)	FAMILY RELATIONSHIPS
Conflicts with parents during adolescence	FAMILY RELATIONSHIPS
Overprotective/Intrusive parent(s)	FAMILY RELATIONSHIPS
Family history of mental health problems	SYMPTOMATOLOGY
Early problems with food intake	LIFE EVENTS
Family history of physical health problems	SYMPTOMATOLOGY
Fears/Worries	EMOTIONS
Self-directed hostility/Low self-esteem	EMOTIONS
Physical aggression in family	FAMILY RELATIONSHIPS
Preoccupation with weight, shape and food	PERSONALITY
History of insecure/ disrupted attachment relationships in family	FAMILY RELATIONSHIPS
Compulsive Self–Reliant/Parental/Pseudo-mature	ATTACHMENT STYLE
Compulsive care-giving	ATTACHMENT STYLE
Anger/Resentment	EMOTIONS
Emotionally cut-off/Avoidant	EMOTIONS
Poor reflective functioning	REFLECTIVE FUNCTIONING
Sadness/depression	EMOTIONS

Loneliness	EMOTIONS
Modelling/Acting/Dancing aspirations	PERSONALITY
Influence of own upbringing on personality and proposed future parenting style	FAMILY RELATIONSHIPS

Depressed group interviews

Early parental separation/reconstituted family	LIFE EVENTS
Perceived absent/neglectful/rejecting parents	FAMILY RELATIONSHIPS
Main attachment figures/caregivers not parents	FAMILY RELATIONSHIPS
Significant early loss	LIFE EVENTS
Disruption/isolation through moving	LIFE EVENTS
Compulsive self-reliance	ATTACHMENT STYLE
Family physical health problems	SYMPTOMATOLOGY
Reported history of parental abuse (physical, sexual and/or emotional)	FAMILY RELATIONSHIPS
Domestic violence/emotional abuse between parents	FAMILY RELATIONSHIPS
Victim of bullying	RELATIONSHIPS WITH PEERS/OTHERS
Angry/aggressive feelings towards parents	EMOTIONS
Feelings of injustice/unfairness	EMOTIONS
Poor relationship with/jealousy of sibling	RELATIONSHIPS WITH PEERS/OTHERS
Separation anxiety	SEPARATION/INDIVIDUATION
Denial/avoidance of memories of painful events	REFLECTIVE FUNCTIONING
Family history of substance misuse	SYMPTOMATOLOGY
Alternative attachment figures/ protective relationships	FAMILY RELATIONSHIPS
Family emphasis on money/ material possessions	FAMILY RELATIONSHIPS
Young, inexperienced parents	FAMILY RELATIONSHIPS
Self-directed hostility/low self-esteem	EMOTIONS
Sexual/romantic relationship difficulties	DEVELOPMENTAL

Influence of own experience on personality and proposed parenting style	FAMILY RELATIONSHIPS
Physical/emotional abuse from sibling	FAMILY RELATIONSHIPS
Strict/disciplinarian parents	FAMILY RELATIONSHIPS
Lack of parental emotional containment	FAMILY RELATIONSHIPS
Impact of religious upbringing	FAMILY RELATIONSHIPS
"Daddy's Girl"	FAMILY RELATIONSHIPS
School problems	RELATIONSHIPS WITH PEERS/OTHERS
Fears/Worries	EMOTIONS
Depression/misery/suicidal feelings	EMOTIONS
Financial problems	LIFE EVENTS
Family mental health problems	SYMPTOMATOLOGY
Compulsive Self-reliance/pseudo-maturity	ATTACHMENT STYLE
Family conflict	FAMILY RELATIONSHIPS
Intense/enmeshed family relationships	FAMILY RELATIONSHIPS
Compulsive care-giving behaviours	ATTACHMENT STYLE
Sexuality/sexual orientation	DEVELOPMENTAL
Peer relationship difficulties	RELATIONSHIPS WITH PEERS/OTHERS
Poor intergenerational attachment history	FAMILY RELATIONSHIPS
Emphasis on achievement	DEVELOPMENTAL
Secretive/withdrawn	PERSONALITY
Early childhood idealised	REFLECTIVE FUNCTIONING
Avoidant narrative style/impoverished RF	REFLECTIVE FUNCTIONING
Poor marital relationship between parents	FAMILY RELATIONSHIPS
Close/secure attachment to mother	FAMILY RELATIONSHIPS
Significant traumatic event (other than parental abuse)	LIFE EVENTS
Family history of physical health problems	SYMPTOMATOLOGY

Fear of loss/death/abandonment	EMOTIONS
Jealousy of parents/others	EMOTIONS
Protective relationships with siblings	RELATIONSHIPS WITH PEERS/OTHERS
Lack of supportive extended family	FAMILY RELATIONSHIPS
Anger/Aggression towards parents	EMOTIONS
Parental problems/worries	SYMPTOMATOLOGY
Social isolation	RELATIONSHIPS WITH PEERS/OTHERS
Secretive	PERSONALITY
Separation anxieties	SEPARATION/INDIVIDUATION
Parental marital difficulties	FAMILY RELATIONSHIPS
Jealousy of others	EMOTIONS
Parental over-intrusiveness/overprotection	FAMILY RELATIONSHIPS
Lack of self-confidence	PERSONALITY
Living in a fantasy world	PERSONALITY

Control Group Interviews

Close early relationships with parents	FAMILY RELATIONSHIPS
Attachment security	ATTACHMENT STYLE
Early stability (school, home, jobs etc.)	LIFE EVENTS
Mixed relationships with other family members (good and bad talked about)	FAMILY RELATIONSHIPS
Insight/high reflective capacity	REFLECTIVE FUNCTIONING
Ease with school/peer relationships	RELATIONSHIPS WITH PEERS/OTHERS
Sense of inner integrity/self-worth	PERSONALITY
Some conflicts with peers	RELATIONSHIPS WITH PEERS/OTHERS
Sense of humour	PERSONALITY
Autonomy/responsibility/feeling trusted	SEPARATION/INDIVIDUATION
Easygoing parents	FAMILY RELATIONSHIPS

Supportive parents	FAMILY RELATIONSHIPS
Ease with separations	SEPARATION/INDIVIDUATION
Difficult life events well managed	LIFE EVENTS
Both parents involved in children's upbringing	FAMILY RELATIONSHIPS
Happy childhood	FAMILY RELATIONSHIPS
Absence of significant illnesses/injuries/upsets	LIFE EVENTS
Affectionate families	FAMILY RELATIONSHIPS
Confident/good self-esteem	PERSONALITY
More distant/strict fathers	FAMILY RELATIONSHIPS
Significant losses/bereavements	LIFE EVENTS
Parental appropriate/clear boundaries and discipline	FAMILY RELATIONSHIPS
Fears/worries	EMOTIONS
Physical illness in family	SYMPTOMATOLOGY
Caring/compassionate	PERSONALITY
High expectations of self	PERSONALITY
Parents ambitious for adolescent	FAMILY RELATIONSHIPS
Early separation anxieties, changed later	SEPARATION/INDIVIDUATION
Close relationships with extended family (for some)	FAMILY RELATIONSHIPS
Distant relationship with extended family (for others)	FAMILY RELATIONSHIPS
Lack of family conflict, or easily resolved	FAMILY RELATIONSHIPS
Developing autonomy/independence	SEPARATION/INDIVIDUATION
Parentified/compulsive care-giving	ATTACHMENT STYLE
Self-directed hostility/low self-esteem	EMOTIONS
Anxious/fearful	EMOTIONS
Shy/unassertive	PERSONALITY
Alternative protective attachment figures	RELATIONSHIPS WITH PEERS/OTHERS
Strict/emotionally abusive parents	FAMILY RELATIONSHIPS

Problems in peer relationships	RELATIONSHIPS WITH PEERS/OTHERS
Emotionally cut-off/avoidant	EMOTIONS
Intergenerational transmission of parenting styles	FAMILY RELATIONSHIPS

APPENDIX 24 – GLOSSARY OF IMPORTANT CONCEPTS*

ADULT ATTACHMENT INTERVIEW (AAI)

A semi-structured psychodynamic interview in which the participant is encouraged to talk about their early attachments, their feelings about their parents and to describe any significant losses and childhood traumata. The AAI infers attachment style from the process and quality of reporting of childhood relationships with parents, as much as upon the interview content and aims to distinguish between different states of mind in respect to attachment. Participants are asked first to choose five adjectives to describe their relationship to both parents and then to explain their choice of those adjectives. Later, they are asked what they did when upset as a child and, following a series of probes, whether they could remember being held for comfort by their parents as a child. They are asked whether they had ever felt rejected in their childhood and if so, why they now thought their parents behaved as they did. They are finally asked whether their parents had ever threatened separation, whether there had been any major changes in relationships with parents since childhood and how they felt about their parents currently. Questions aim to elicit both episodic and semantic aspects of memory storage and retrieval and opportunities are offered for interviewees to contradict or fail to support claims they have made. The transcripts are then rated, not so much for content as for style, picking up features like coherence of the narrative and capacity to recall painful events. Participants are then classified into one of four categories: 'Free to evaluate attachment', 'dismissing of attachment', 'enmeshed in attitudes towards attachment' and 'unresolved/ disorganised/ disorientated'. When given to pregnant mothers, the AAI has been shown to predict the attachment status of the infants at one year with 70 percent accuracy (Fonagy, Steele and Steele, 1992).

BORDERLINE PERSONALITY DISORDER (BPD)

A term used rather differently by psychiatrists and psychotherapists to denote a group of difficult and disturbed patients characterised primarily by instability of mood and difficulty sustaining close relationships. In addition, they often show self-injurious behaviour such as self-harm and drug abuse; have destructive, angry outbursts; suffer from identity disturbance with uncertainty about life goals and sexual orientation; and experience chronic feelings of emptiness and boredom. Although a precise definition is difficult, the term captures the sense of an individual who often lives on the borderline of relationships, neither in nor out of them and, psychologically, on the borderline between neurosis and psychosis.

CONTAINMENT/CONTAINER

Model proposed by psychoanalyst Wilfred Bion (1962) to explain the processing of early emotional experience. Bion thought that the baby's capacity to take in sense impressions and complex emotional reactions develops in relation to the same capacities in the mother. Parents (mothers) who are not preoccupied with their own psychological distress or unresolved trauma will be able, according to Bion, to receive their infants' projections of distress (i.e. their externalisation of distress and putting distress 'into' the mother) and need and to contain these. The infants needs and feelings can then be processed by the mother and put back to the child in a manageable, acceptable form, thus enabling the child to feel able to bear their distress because the mother is able to bear it. Frightened, frightening or traumatised parents are, however, unable to contain their child's projections of anxiety and, indeed, will be likely to project anxiety/distress of their own. This will give the child not only the experience of a parent unable to provide an adequate container for their distress, but that the child must contain the uncontained distress of the parent, experienced as intrusive "foreign bodies" (Williams, 1997).

ETHOLOGY/ETHOLOGICAL

Literally, the study of an individual's 'ethos' or character. Ethology is a biological science, which studies animal behaviour in a particular way: the animal is considered as a whole; behaviour is usually studied in natural or wild conditions; there is great attention to the antecedents and consequences of behaviour patterns; the function of any behaviour is considered and an evolutionary perspective is always taken. An attempt is made to see how the animal views the world from its own perspective and to visualise the internal 'maps' and rules, which govern its activities. Ethology is contrasted with behaviourism, which usually concentrates on particular bits of behaviour and does not consider the organism as a whole and is unconcerned with evolutionary considerations. Bowlby saw the methods and theories of ethology as highly relevant to the study of human infants and this led to a fruitful collaboration between him and leading ethologist Robert Hinde (see Hinde, 1982 a and b; 1987).

INTERNAL WORKING MODEL (IWM)

On the basis of cognitive psychology (e.g. Craik, 1943; Beck et al., 1979), Bowlby saw higher animals as needing a map/model of the world in the brain, if they were to successfully predict, control and manipulate their environment. In Bowlby's version, humans have two such models, an 'environmental' model, telling us about the world and an 'organismal' model, telling us about ourselves in relation to the world. We carry a map of self and others and the relationship between the two. Although primarily 'cognitive' in conceptualisation, the idea of working models is applicable to affective life. The map is built from experiences and is influenced by the need to defend against painful feelings. Thus an anxiously attached child may have a model of others in which they are potentially dangerous, and therefore must be approached with caution, whilst their self-representation may be of someone who is demanding and needy and unworthy to be offered security. The relationship with a person's primary caregivers is generalised in internal working models, which leads to a distorted and incoherent picture of the world, and one that is not subject to updating and revision in the light of later experience (although this idea has been challenged). This, in Bowlby's eyes, is the basis for transference, and the task of therapy is to help the patient develop more realistic and less rigid internal working models.

MATERNAL DEPRIVATION

A phrase summarising Bowlby's early work on the effects of separating infants and young children from their mothers. Bowlby believed that maternally deprived children were likely to develop asocial or antisocial tendencies and that juvenile delinquency was mainly a consequence of such separations. The corollary of this was his advocacy of continuous mother-child contact for at least the first five years of life, which earned him the opprobrium of feminists. Subsequent research has confirmed that lack of maternal care does lead to poor social adjustment and relationship difficulties but suggests that disruption, conflict and poor maternal handling are more common causes of difficulties in later life than the loss of the mother in itself.

'MATERNAL REVERIE'

Psychoanalytic concept invented by Bion (1962) referring to a mother's capacity to hold her baby's anxiety and her own and to go on thinking even in the face of puzzling and increasingly intense protest and distress, drawing on and offering inner resources. The mother gradually dispels the baby's distress, seeking to engage with it rather than to explain it. She is able to tolerate not knowing its source. She restrains herself from diverting the true meaning of the experience by prematurely offering a solution. She gently talks, rocks, feeds, and reflects until the baby, basking in the calm of trustful intimacy, begins to recover.

META (COGNITIVE) – MONITORING (see also 'Reflective Functioning')

Concept introduced by Main (1990) and Fonagy (1991) to denote the ability to 'think about thinking'. Securely attached children and adults are able to reflect freely on their thought

processes (e.g. "I was really upset when my Mum and Dad split up and felt pretty hostile to all the children at school who seemed to have happy homes"), in contrast to insecure individuals, who tend either to dismiss their thought processes (e.g. "Oh the split up didn't affect me at all, I just concentrated on my football") or to be bogged down in them ("I can't really talk about it...it makes me too upset"). Deficiencies in meta-monitoring are common in pathological states, such as Borderline Personality Disorder, and one of the aims of psychotherapy is to facilitate metacognition.

MONOTROPISM

An ethological (see above) term introduced by Bowlby to denote the exclusive attachment of a child to its principal care-giver, usually the mother. He was impressed by Lorenz's (1952) studies of geese and their young which suggested that the goslings became 'imprinted' onto a moving object at a sensitive period in the first day or two of life. Bowlby thought that a similar process occurred in humans. In fact, imprinting seems not to be a feature of primate development, where attachments develop gradually and over a wide range from the early months to adolescence. Also, attachment in humans is not so much monotropic as hierarchical, with a list of preferred care-givers, with parents at the top, but closely followed by grandparents, siblings, aunts etc.

REFLECTIVE FUNCTIONING (See also Meta-Monitoring and Appendix 11 – Reflective Functioning Scale)

A term similar to 'mentalising': the ability to reflect on personal and interpersonal issues and to see others as people with mental states of their own. Fonagy et al. (1995) see this as a developmental task that only emerges in the context of a secure attachment relationship. This capacity involves the subject's ability to think of himself and others as separate people, capable of thinking and feeling, whose behaviour is motivated by underlying mental states and knowledge which emerges from sources which can be clearly identified and defined. The concept of reflective function arises in part from Mary Main's (1991) work on 'metacognitive monitoring' and partly from the work of a number of psychoanalysts who discussed the characteristics and importance of being able to think about personal and interpersonal events, particularly in terms of the connection between one's own mental states and those of others (e.g. Bion 1962 a, b; Kohut, 1977).

Fonagy and colleagues have studied transcripts of the AAI to assess quality of reflective function and have also demonstrated that individual differences in reflective function are rooted in the presence or absence of attachment security (Fonagy et al 1991, 1997). Reflective Functioning could be seen as a more specific way of thinking about oneself and the world, which is intertwined with ego functions (e.g. Bellak, Hurvich and Gediman, 1973): the capacities for reality-testing, judgement, regulation and control of affects and impulses and thought processes. Clinical experience shows that optimal functioning in all these areas depends upon the quality of early attachment relationships and, in turn, affects the way adults treat their children. Consistency of behaviour, predictability, emotional stability, good judgement, and non-distorted perception of the child's emotional states, motives and needs are all related to ego-functioning.

SECURE BASE

A term introduced by Ainsworth (1982) and reinforced by Bowlby (1988) to describe the feeling of safety provided by an attachment figure. Children will seek out their secure base at times of threat – danger, illness, exhaustion or following a separation. When the danger has passed, attachment behaviour will cease, but only if it is there to be mobilised if needed will the child feel secure. The secure phenomenon applies equally to adults. We all feel "at home" with those whom we know and trust, and within such a home environment we are able to relax and pursue our projects, whether they be play, pleasure-seeking or work.

STRANGE SITUATION

An experimental method devised by Ainsworth (e.g. Ainsworth et al., 1978) to study the ways in which one-year-old children can cope with brief separations from their caregivers. The child is first recorded playing with his/her mother and them left, first with the experimenter and then alone while the mother goes out of the room for three minutes. The child's response to the separation, and more importantly, to the re-union, is observed and rated on videotapes. On the basis of this rating, children can be classified as secure (usually characterised by brief protest followed by a return to relaxed play and interaction) or insecure (the latter being subdivided into avoidant and ambivalent patterns of insecurity.

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* Acknowledgement must be made to Holmes (1993) and Waddell (1998) in the definition of these concepts.

APPENDICES 25-37:

RAW DATA TABLES

Appendix 25: Symptom scores across the three groups of adolescents

	EATING DISORDERED			DEPRESSED			CONTROL		
	YSR problem score & significance	BDI II score and level	Total SEDS score/ level	YSR problem score and significance	BDI II score and level	Total SEDS score/ Level	YSR problem score and significance	BDI II score and level	Total SEDS score/ level
1	133 v. high clinical	52 severe	245.4 clinical	93 clinical	18 mild	102.4 non-clinical	65 borderline	7 not depressed	53.8 not clinical
2	29 non-clinical	14 mild	116.9 clinical	82 clinical	20 moderate	101.9 non-clinical	30 non-clinical	4 not depressed	17.3 not clinical
3	67 borderline clinical	9 not depressed	138.3 clinical	70 clinical	16 mild	52.8 non-clinical	30 non-clinical	10 not depressed	77.6 not clinical
4	49 non-clinical	13 not depressed	131.7 clinical)	88 clinical	15 mild	57.2 non-clinical	58 borderline	7 not depressed	101.6 not clinical
5	71 clinical	33 severe	165.9 clinical	52 normal range	18 mild	95.6 non-clinical	56 borderline	6 not depressed	16.7 not clinical
6	73 clinical	14 mild	135.1 clinical	89 clinical	36 severe	99.5 non-clinical	47 normal	12 not depressed	17.8 not clinical
7	77 clinical	24 moderate	160 clinical	114 high clinical	29 severe	96.9 non-clinical	34 non-clinical	13 not depressed	98.4 not clinical
8	98 clinical	45 severe	240.2 clinical	118 high clinical	55 severe	99.7 non-clinical	76 clinical	13 not depressed	58.9 not clinical
9	62 non-clinical	15 mild	241.8 clinical	80 clinical	16 mild	67.5 non-clinical	54 non-clinical	8 not depressed	24.8 not clinical
10	73 clinical	16 Mild	154.7 clinical	115 high clinical	26 moderate	87.1 non-clinical	35 non-clinical	9 not depressed	84.4 not clinical
Mean	**73.2**	**23.5**	**173**	**90.1**	**24.9**	**86.06**	**48.5**	**8.9**	**55.13**

Appendix 26 : Adolescent PBI Scores across the three groups

	EATING DISORDERED			DEPRESSED			CONTROL		
	Care	Over-Protection	Bonding type	Care	Over-Protection	Bonding type	Care	Over-Protection	Bonding type
1	29	17	Affectionate constraint	24	22	Affectionless Control	30	10	Optimal
2	35	15	Affectionate constraint	28	12	Optimal	34	9	Optimal
3	24	10	Neglectful	24	14	Affectionless control	35	8	Optimal
4	36	7	Optimal	27	7	Optimal	20	22	Affectionate constraint
5	15	21	Affectionless control	24	8	Neglectful	32	13	Optimal
6	33	12	Optimal	30	9	Optimal	36	1	Optimal
7	13	20	Affectionless control	22	10	Neglectful	34	8	Optimal
8	14	14	Affectionless control	9	24	Affectionless control	25	5	Optimal
9	25	31	Affectionate constraint	11	19	Affectionless control	34	5	Optimal
10	15	22	Affectionate constraint	12	22	Affectionless control	24	13	Affectionate constraint

Appendix 27 : Adolescent ARAQ attachment patterns across the three groups of adolescents

	EATING DISORDERED				DEPRESSED				CONTROL			
	AW	CCG	CSR	CCS	AW	CCG	CSR	CCS	AW	CCG	CSR	CCS
1.	16	20	25	14	10	24	21	14	12	15	22	14
2.	14	21	16	21	14	22	18	23	15	17	17	22
3.	17	26	18	12	24	19	20	16	12	20	18	27
4.	15	24	10	28	14	27	18	19	18	22	21	16
5.	30	26	29	16	7	14	24	12	9	24	17	16
6.	11	26	12	20	14	29	13	16	15	23	16	15
7.	No	attach	ment	figure	16	23	21	25	11	19	16	19
8.	16	27	19	5	30	27	29	12	14	21	23	12
9.	14	26	10	28	14	21	17	14	15	19	14	14
10.	12	24	14	22	14	26	22	14	12	28	15	15

KEY

AW = Angry Withdrawal
CCG = Compulsive Care-Giving
CSR = Compulsive Self-Reliance
CCS = Compulsive Care-Seeking

Appendix 28: Scores obtained by Adolescents across the three groups on the subscales of the Separation-Individuation Test of Adolescence

	Engulfment Anxiety	Practicing Mirroring	Dependency Denial	Separation Anxiety	Nurturance/ Caretaker Enmeshment	Healthy Separation	Rejection Expectancy
1. ED	35.71	21.33	36.67	34.29	33.75	41.43	37.5
2. ED	25.71	17.33	18.33	25	35	38.57	23.33
3. ED	34.3	30.7	20.8	32.1	28.8	45.7	26.7
4. ED	32.86	24	15	25	27.5	48.57	17.5
5. ED *	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6. ED	30	30	15	30	31.25	45.71	17.5
7. ED	41.43	22	20	32.31	23.75	38.57	34.17
8. ED	22.86	18	22.5	31.54	28.75	41.43	31.67
9. ED	29.29	20.67	28.56	33.92	31.25	37.57	34.59
10. ED	31.63	24.08	23.18	31.62	38.29	41.18	22.87
1. DEP	40	32	21.67	29.29	30	37.14	31.67
2. DEP	27.14	30	15.83	39	27.5	47.14	27.5
3. DEP	34.29	24	20	37.14	23.75	40	28.33
4. DEP	22.86	24.67	17.5	22.86	25	41.43	20.83
5. DEP	24.29	29.33	23.33	31.54	25	31.43	26.67
6. DEP	27.14	36	26.67	34.62	28.75	41.43	25
7. DEP	31.67	24.67	20.83	32.14	21.25	31.43	36.67
8. DEP	47.14	21.92	31.35	43.87	21.25	28.67	43.46
9.DEP	27.14	32.67	20.83	25.71	21.25	40	30.83
10. DEP	34.29	24.67	26.67	37.14	25	31.43	28.33
1. CONT	24.3	18.7	21.7	27.1	30	35.7	19.2
2. CONT	24.29	28	15.83	28.57	26.25	34.29	22.5
3. CONT	24.29	30	20	35	35	45.71	19.17
4. CONT	38.5	23.3	24.2	27.9	18.8	44.3	30
5. CONT	30	25.33	19.17	22.14	17.5	42.86	22.5
6. CONT	20	34.67	19.17	30	30	37.14	15
7. CONT	27.14	27.33	15.83	28.57	32.86	41.43	19.17
8. CONT	20	27.33	27.5	42.1	21.3	35.7	21.7
9. CONT	22.86	29.33	20.83	27.86	35	41.43	15
10. CONT	41.43	29.33	23.3	31.4	25	41.43	25

KEY

* = Did not complete measure
ED = Eating disordered Group
DEP = Depressed Group
CONT = Control Group

Appendix 29: Scores obtained on the FACES II across the three groups of adolescents.

	EATING DISORDERED			DEPRESSED			CONTROL		
	Cohesion	Adaptability	Family type	Cohesion	Adaptability	Family Type	Cohesion	Adaptability	Family type
1	51 (Sep)	43 (Str)	3.5 (Mid)	49 (Dis)	40 (Str)	2.5 (Ext)	57 (Sep)	38 (Rig)	3 (Mid)
2	71 (VC)	51 (Fle)	6.5 (MB)	56 (Sep)	42 (Str)	3.5 (Mid)	66 (Con)	51 (Fle)	6 (MB)
3	40 (Dis)	43 (Str)	3 (Mid)	49 (Dis)	41 (Str)	2.5 (Ext)	63 (Con)	48 (Fle)	5 (MB)
4	60 (Con)	48 (Fle)	5 (MB)	51 (Sep)	44 (Str)	3.5 (Mid)	48 (Dis)	44 (Str)	3 (Mid)
5	27 (Dis)	31 (Rig)	1.5 (Ext)	46 (Dis)	29 (Rig)	2 (Ext)	59 (Sep)	47 (Fle)	4.5 (Mid)
6	63 (Con)	50 (Fle)	5.5 (MB)	42 (Dis)	40 (Str)	2.5 (Ext)	67 (Con)	58 (VF)	6.5 (MB)
7	34 (Dis)	24 (Rig)	1 (Ext)	36 (Dis)	39 (Rig)	2 (Ext)	64 (Con)	43 (Str)	4.5 (Mid)
8	43 (Dis)	35 (Rig)	2 (Ext)	34 (Dis)	29 (Rig)	1 (Ext)	46 (Dis)	40 (Str)	2.5 (Ext)
9	61 (Con)	47 (Fle)	5 (MB)	41 (Dis)	33 (Rig)	1.5 (Ext)	61 (Con)	50 (Fle)	5.5 (MB)
10	47 (Dis)	35 (Rig)	2 (Ext)	41 (Dis)	29 (Rig)	1.5 (Ext)	68 (Con)	49 (Fle)	5 (MB)

KEY:

Cohesion

VC = Very connected
Con = Connected
Sep = Separated
Dis = Disengaged

Adaptability

VF = Very Flexible
Fle = Flexible
Str = Structured
Rig = Rigid

Family Type

B = Balanced
MB= Moderately Balanced
Mid =Mid-range
Ext = Extreme

Appendix 30: Parental BDI II Scores

Group	Parent 1 (M) score and level	Parent 2 (F) score and level
EATING DIS.	9 – Not depressed	0 – Not depressed
EATING DIS.	10 – not depressed	N/A
EATING DIS.	9 – Not depressed	10 – Not depressed
EATING DIS.	16 – Mild	N/A
EATING DIS.	9 – Not depressed	N/A
DEPRESSED	6 – Not depressed	N/A
DEPRESSED	2 – Not depressed	N/A
DEPRESSED	6 – Not depressed	N/A
DEPRESSED	23 – moderate	N/A
DEPRESSED	3 – not depressed	0 – not depressed
DEPRESSED	1 – not depressed	6 – not depressed
CONTROL	18 – depressed (mild)	N/A
CONTROL	1 – Not depressed	6 – Not depressed
CONTROL	1 – Not depressed	6 – Not depressed
CONTROL	4 – Not depressed	1 – Not depressed
CONTROL	0 – Not depressed	1 – Not depressed
CONTROL	6 – Not depressed	6 – Not depressed
CONTROL	9 – Not depressed	20 – depressed (mild/mod.)
CONTROL	6 – Not depressed	1 – Not depressed

Appendix 31 : Parental (Young) Adult Self-Report Problem Scale Scores

Parent Group	YASR scores and levels
ED	59 (clinical range)
ED	73 (high clinical range)
ED	30 (normal range)
ED	8 (normal range)
ED	73 (high clinical range)
ED	41 (normal range)
ED	46 (normal range)
Mean ED	**47.14**
DEP	53 (normal range)
DEP	32 (normal range)
DEP	45 (normal range)
DEP	87 (v. high clinical range)
DEP	34 (normal range)
DEP	16 (normal range)
DEP	20 (normal range)
DEP	33 (normal range)
Mean Depressed	**40**
CONT	40 (normal range)
CONT	25 (normal range)
CONT	61 (clinical range)
CONT	28 (normal range)
CONT	35 (normal range)
CONT	53 (normal range)
CONT	32 (normal range)
CONT	21 (normal range)
CONT	12 (normal range)
CONT	38 (normal range)
CONT	21 (normal range)
CONT	49 (normal range)
CONT	49 (normal range)
CONT	53 (normal range)
CONT	32 (normal range)
Mean Control	**36.6**

Appendix 32 : Parental PBI Scores across the three groups

Parent group	Care	Over-Protection	Bonding type
1. ED	30	6	Optimal
2. ED	25	18	Affectionate Constraint
3. ED	24	20	Affectionate Constraint
4. ED	24	14	Optimal
5. ED	20	25	Affectionless Control
6. ED	24	13	Neglectful
7. ED	26	8	Optimal
8. DEP	28	7	Optimal
9. DEP	32	13	Optimal
10. DEP	36	6	Optimal
11. DEP	26	19	Affectionate Constraint
12. DEP	36	6	Optimal
13. DEP	29	13	Optimal
14. DEP	35	24	Affectionate Constraint
15. DEP	30	14	Optimal
16. CONTROL	11	13	Neglectful
17. CONTROL	35	13	Optimal
18. CONTROL	35	13	Optimal
19. CONTROL	20	24	Affectionate Constraint
20. CONTROL	28	17	Affectionate Constraint
21. CONTROL	36	8	Optimal
22. CONTROL	15	18	Affectionless Control
23. CONTROL	36	13	Optimal
24. CONTROL	30	24	Affectionate Constraint
25. CONTROL	30	24	Affectionate Constraint
26. CONTROL	31	6	Optimal
27. CONTROL	29	7	Optimal
28. CONTROL	23	6	Neglectful
29. CONTROL	26	2	Optimal
30. CONTROL	24	10	Neglectful

Appendix 34: Adolescent and corresponding parent BDI II and Self-Report form Scores (YSR and YASR)

	Adol Score BDI II	Parent 1 Score BDI II	Parent 2 Score BDI II	Adol. Score YSR	Parent 1 Score YASR	Parent 2 Score YASR
1. ED	52	9	0	133	73	8
2. ED	14	10	-	29	59	-
3. ED	13	9	10	49	30	73
4. ED	33	16	-	71	41	-
5. ED	14	9	-	73	46	-
6. DEP	18	6	-	93	45	-
8. DEP	20	2	-	82	20	-
7. DEP	15	6	-	88	34	-
8. DEP	36	23	-	89	87	-
9. DEP	29	3	-	114	33	16
10. DEP	26	1	6	115	32	53
11. CONT	7	18	-	30	61	-
12. CONT	4	1	6	30	32	53
13. CONT	10	1	6	58	32	53
14. CONT	7	4	1	56	40	25
15. CONT	6	0	1	47	21	12
16. CONT	13	6	6	76	28	35
17. CONT	13	9	20	54	49	49
18. CONT	8	6	1	35	38	21

APPENDIX 35 : CORRESPONDING ADOLESCENT AND PARENT PBI SCORES

Participant group	'Care' Score			'Overprotection' Score		
	Adol	Parent 1(M)	Parent 2 (F)	Adol	Parent 1	Parent 2
1. ED	29	30	25	17	6	18
2. ED	35	24	N/A	15	20	N/A
4. ED	36	24	20	7	14	25
5. ED	15	24	N/A	21	13	N/A
6. ED	33	26	N/A	12	8	N/A
7. DEP	24	28	N/A	22	7	N/A
8. DEP	28	32	N/A	12	13	N/A
9. DEP	22	36	29	10	6	14
10. DEP	30	26	N/A	9	19	N/A
11. DEP	23	35	30	31	13	24
12. DEP	27	36	N/A	7	6	N/A
13. CONT	30	11	N/A	10	13	N/A
14. CONT	34	35	30	9	13	24
15. CONT	35	35	30	8	13	24
16. CONT	20	20	31	22	24	6
17. CONT	32	28	29	12	17	7
18. CONT	34	36	23	8	8	6
19. CONT	25	15	26	5	18	2
20. CONT	34	36	24	5	13	10

Appendix 36 : Corresponding Adolescent and Parent ARAQ Scores

	Angry Withdrawal			Compulsive Care-giving			Compulsive Care-seeking			Compulsive Self-Reliant		
	Adol.	Parent 1 (M)	Parent 2 (F)	Adol	Parent 1	Parent 2	Adol.	Parent 1	Parent 2	Adol	Parent 1	Paren 2
1. ED	16	10	8	20	19	31	14	15	10	25	14	8
2. ED	14	12	N/A	21	19	N/A	21	17	N/A	16	13	N/A
3. ED	15	14	11	24	19	33	28	11	20	10	13	23
4. ED	30	26	N/A	26	32	N/A	16	17	N/A	29	14	N/A
5. ED	11	20	N/A	26	20	N/A	14	19	N/A	21	20	N/A
6. DEP	10	16	N/A	24	20	N/A	14	19	N/A	21	20	N/A
7. DEP	14	14	N/A	22	22	N/A	23	15	N/A	18	14	N/A
8. DEP	14	15	N/A	27	23	N/A	19	13	N/A	18	11	N/A
9. DEP	14	14	N/A	29	22	N/A	16	11	N/A	13	13	N/A
10. DEP	16	13	10	23	23	16	25	12	12	21	13	20
11. CON	12	16	N/A	15	29	N/A	14	17	N/A	22	15	N/A
12. CON	15	11	9	17	25	25	22	20	14	17	9	11
13. CON	12	11	9	20	25	25	27	25	25	18	25	25
14. CON	18	10	14	22	26	23	16	21	15	21	15	18
15. CON	9	12	8	24	30	24	16	16	14	17	11	12
16. CON	11	13	13	19	21	14	19	14	13	16	22	18
17. CON	14	21	N/A	21	19	N/A	12	17	N/A	23	22	N/A
18. CON	15	16	11	19	24	27	14	17	11	14	16	9

1x control parent did not complete the measure

2 x parents (1 depressed, 1 control) said they had no attachment figure.

Appendix 37 : Corresponding parental and adolescent FACES II scores

Group	Cohesion Score			Adaptability Score			Family Type		
	Adol.	P1 (M)	P2 (F)	Adol.	P1	P2	Adol.	P1	P2
Eating Disordered									
1.	51 Sep	66 Con	72 Con	43 Str	56 VF	52 F	3.5 Mid	6.5 B/MB	6.5 B/MB
2.	71 VC	65 Con	N/A	51 Fle	49 Fle	N/A	6.5 MB	4.5 MR	N/A
3.	40 Dis	N/A	N/A	43 Str	N/A	N/A	3 Mid	N/A	N/A
1.	60 Con	71 VC	67 Con	48 Fle	58 VF	51 F	5 MB	7 B	6 MB
2.	27 Dis	54 Sep	N/A	31 Rig	49 Fle	N/A	1.5 Ext	4 Mid	N/A
3.	63Con	65 Con	N/A	50 Fle	53 Fle	N/A	5.5 MB	6 MB	N/A
4.	34 Dis	N/A	N/A	24 Rig	N/A	N/A	1 Ext	N/A	N/A
5.	43 Dis	N/A	N/A	35 Rig	N/A	N/A	2 Ext	N/A	N/A
6.	61Con	N/A	N/A	47 Fle	N/A	N/A	5 MB	N/A	N/A
10.	47 Dis	N/A	N/A	35 Rig	N/A	N/A	2 Ext	N/A	N/A
Depressed									
1.	49 Dis	N/A	N/A	40 Str	30 Rig	N/A	2.5 Ext	2.5 Ext	N/A
2.	56 Sep	27 Dis	N/A	42 Str	41 Stru	N/A	3.5 Mid	3 Mid	N/A
3.	49 Dis	N/A	46 Dis	41 Str	N/A	N/A	2.5 Ext	N/A	N/A
4.	51 Sep	51 Sep	N/A	44 Str	N/A	N/A	3.5 Mid	N/A	N/A
5.	56Sep	53 Sep	N/A	29 Rig.	39 Rig	N/A	2 Ext	1.5 Ext	N/A
6.	46 Dis	N/A	N/A	40 Str	N/A	42 Str	2.5 Ext	N/A	2.5 Ext
7.	42 Dis	65 Con	N/A	39 Rig	N/A	N/A	2 Ext	N/A	N/A
8.	34 Dis	N/A	N/A	29 Rig	N/A	N/A	1 Ext	N/A	N/A
9.	41 Dis	N/A	N/A	33 Rig	55 VF	59VF	1.5 Ext	7.5B	7.5B
10.	41 Dis	74 VC	78VC	29 Rig	N/A	N/A	1.5 Ext	N/A	N/A
Control									
1.	57 Sep	69 Con	N/A	38 Rig	50 Fle	N/A	3 Mid	6 MB	N/A
2.	66 Con	74 VC	78VC	51 Fle	55 VF	59VF	6 MB	7.5B	7.5B

3.	63 Con	74VC	78VC	48 Fle	55VF	59VF	5MB	7.5B	7.5B
4.	48 Dis	61 Con	64 Con	44 Stru	47 Fle	47 Fle	3 Mid	5MB	5MB
5.	59 Sep	63 Con	73 VC	47 Fle	47 Fle	51 Fle	4.5 Mid	5 MB	6.5MB
6.	67 Con	N/A	N/A	58 VF	N/A	N/A	6.5 MB	N/A	N/A
7.	64 Con	62 Con	56 Sep	43 Stru	48 Fle	52 Fle	4.5 Mid	5 MB	5 MB
8.	46 Dis	56 Sep	45 Dis	40 Stru	50 Fle	37 Rig	2.5 Ext	5 MB	2 Ext
9.	61 Con	58 Sep	59 Sep	50 Fle	47 Fle	37 Rig	5.5 MB	4.5 Mid	3 Mid
10.	63 Con	N/A	N/A	49 Fle	N/A	N/A	5MB	N/A	N/A

KEY

Cohesion	**Adaptability**	**Family Type**
VC = Very connected	VF = Very Flexible	B = Balanced
Con = Connected	Fle = Flexible	MB= Moderately Balanced
Sep = Separated	Str = Structured	Mid =Mid-range
Dis = Disengaged	Rig = Rigid	Ext = Extreme